I. Executive Summary

Community-based emergency medical services (EMS) find themselves somewhere between the all-volunteer, first-aid care, donation-funded rescue service which first came to be and the all-paid, paramedic care, municipally subsidized, patient-charging fire, municipal, commercial or other services now common in most areas.

Why this change? The public’s expectation of the EMS professionals who arrive at their door has changed, and is now more sophisticated, probably as a result of television shows that feature EMS. Before 1973 (when the TV program “Emergency” had begun to air with the first “paramedics”), the public expected no more than a lights and siren, horizontal taxi ride to the hospital. By 1983, the public didn’t know whether to expect just the fast ride to the hospital or some real life-saving care in the back of the ambulance. But by 1993, a Maine EMS study showed that almost 90% of Maine’s citizens expect the highest level of EMS capabilities (paramedic) to arrive at their doorstep for their heart attack. And they expect it to arrive fast. Seventeen years later, there is no reason to believe that this expectation has eroded.

The St. George Volunteer Firefighters and Ambulance Association (SGVFAA) Ambulance Service is an increasingly unique entity as similar services in Maine and the Nation turn to pay incentives to attract and retain staff to assure fast response and ALS availability. The St. George Ambulance is a volunteer service of Maine tradition which continues its unpaid and non-charging service to the community, while striving to match patient need with the highest advanced life support (ALS) available. Most of its dedicated staff are proud of this and would like to continue on this path of service. However, uncertainty about its ability to be successful in meeting response expectations without pay incentives and without charging patients for service to support pay incentives, in large part led to this evaluation. More generally, however, the SGVFAA Executive Committee wishes to be assured that the future EMS needs of St. George will be met, and sought an objective, outside expert’s perspective on this.

The evaluation found an adequately performing ambulance service with the hallmarks of a lower volume volunteer service: good and well-maintained equipment, more than adequate supplies but without reliable inventorying levels and restocking system. There are generally good response times with great patient care and documentation when ALS personnel are in town, less so when the service is responding only at its EMT-Basic license level with use of mutual aid ALS from nearby municipalities. Also found was a staff generally focused on its patient care mission but notably challenged by internal politics and personality conflicts. Matters have not been helped by a cumbersome and sometimes vague governance and command organizational structure which challenges the
minimally stipended ambulance director who is expected to be an excellent leader by example, a meticulous communicator, an administrator of every detail, and who must dedicate hundreds of hours a year to keep the ship afloat. This report recommends organizational and operating changes to plug holes in the hull.

The issues of whether to offer pay incentives and whether to begin charging patients are also addressed. The report recommends that a modest Town subsidy may need to be sought for two specific purposes (establishing an EMS command structure and providing non-monetary incentives for volunteers). There are, however, no single recommendations regarding pay and patient charging except to suggest that triggers for the actions be established through an “informed self-determination process” in a special Town forum to get citizen direction since, one way or another, they pay the bills and receive the services. It is recommended that the ambulance remain an independent service under an EMS Chief and support command structure.

An important recommendation this evaluation report makes is that St. George resume previous efforts to explore models of shared EMS operations with at least Thomaston and South Thomaston. St. George has made a miraculous effort to maintain one of the last true volunteer services standing.

II. Purpose and Format of the Evaluation

ASMI consultant Kevin McGinnis conducted an independent, objective evaluation of emergency medical services capabilities and needs in the town of St. George for the SGVFAA. This evaluation produced written recommendations to SGVFAA.

More specifically, the study and recommendations focused on the following areas.

A. St. George Volunteer Firefighters and Ambulance Association EMS in 2010: What It Is & Where It Came From
This is an historical and quantitative picture of the services now provided. It should provide decision-makers with a foundation of critical information from call response profiles (call volumes, types, times, level of care and other response characteristics in recent years) to current staffing methods. This information also describes the service in comparison with two other services in Maine, Northeast Harbor and Ashland, which have similar run volumes and which have similarly isolated response areas (one on an island and the other in the North Woods).

B. St. George Volunteer Firefighters and Ambulance Association EMS in 2010: Capabilities and Performance
This is a qualitative look at the functional effectiveness of the service. It is organized to assess the following critical components: governance, general operations, patient care, facilities and equipment, staffing, training, safety, budgeting/finance, and community relations/services.

The St. George Volunteer Firefighters and Ambulance Association EMS of 2010 is the *indirect* product of the EMS and health care system, financial, governmental, and local social/political environments in which the service operates. It will be the *direct* product of the SGVFAA and town’s decision-makers.

This section takes the St. George Volunteer Firefighters and Ambulance Association organization, as profiled in the previous two sections, and analyzes its strengths and weaknesses in those environments, as well as the opportunities and threats (a formal “SWOT” analysis) those environments pose for it over the next few years. **ASMI** then offers recommendations for assuring excellence as both a patient care service, as an investment of donation-based, tax-based, and patient-based resources (as recommended), and as a community service. An actual SWOT exercise was conducted during the evaluation with the SGVFAA designated Project Working Group for the project.

III. Methods, Deliverables and Work Performed

The following describes the methods utilized and work accomplished for each area of the evaluation. **Note:** The findings and recommendations in this document are heavily dependent on information discovered through review of materials provided by SGVFAA and the confidential interviews of individuals. Findings based on interviews reflect a sufficient number and quality of sources to create a pattern leading to those findings. Findings based on materials reviewed can only reflect documents and other forms of information provided.

A. St. George Volunteer Firefighters and Ambulance Association in 2010: What It Is & Where It Came From

Mr. McGinnis:

- Researched Maine EMS (MEMSRR)/Maine Health Information Center (MHIC) standard reporting data since 2000, within the constraints of the recently changed Maine EMS run record data system, to synthesize a picture of the St. George Volunteer Firefighters and Ambulance Association EMS and its basic response characteristics. Contrasts are drawn with regional and statewide characteristics and with two other services in the State, Northeast Harbor and Ashland, that have roots and other characteristics similar to the St. George service, but which have employed operational methods (e.g. employees, incentive pay, patient billing, town subsidy) that have only been mentioned as a consideration in St. George.
- Requested and reviewed all town and service reports and other materials with EMS-relevant historical interest.

- Requested and reviewed MEMS licensing information and regional EMS information with historical significance to the service and towns.

- Conducted interviews with all SGVFAA EMS (and some fire) members who requested to be interviewed as well as others recommended by the Project Working Group that could be reached. Conducted interviews with town and service “opinion-shapers” and leaders including:
  - SGVFAA Ambulance Directors (both because this person changed during the course of the evaluation), Fire Chief, President;
  - Four (five including the recent change) former SGVFAA Ambulance Directors;
  - Other SGVFAA officers (included the Deputy Fire Chief, two Assistant Fire Chiefs, all Fire Captains and Lieutenants);
  - Four of the five members of the Select Board;
  - Five of the most active members of the Citizens Advisory Committee
  - Chiefs of the South Thomaston (both the recent past director and the current director), Thomaston, and Rockland (both the fire chief and EMS coordinator) ambulance services;
  - The director of Knox Regional Communications Center (the Public Safety Answering Point for St. George);
  - The Knox County Sheriff’s Office Chief Deputy;
  - Three Maine EMS staff members;
  - The Mid-Coast EMS regional coordinator and, through him, the regional medical director; and
  - An emergency physician and emergency department nurse manager (who polled other staff nurses) at Pen Bay Medical Center.

In all, 55 individuals were interviewed in person or by telephone. Seventy-one total interviews were conducted. Some individuals were interviewed two or three times with either continued or follow-up sessions and/or to be re-interviewed following the change of Ambulance Directors in mid-evaluation. This re-interviewing was done at the recommendation of Mr. McGinnis and the approval and request to do so by the Project Working Group. This caused the report delivery to be delayed by a month.

The following individuals were interviewed:

Adams, Carrie (Paramedic, Rockland Fire Department; EMS Officer)
Anonymous (St. George residents and relatives of others interviewed - 3)
Barnes, Trish (Citizens Advisory Group)
Biser, Abby (SGVFAA; EMT)
Blank, Margaret (EMT-P, Northeast Harbor Ambulance Service; Cranberry Isle Rescue)
Bradshaw, Jay (Maine EMS; Director)
Chandler, Walden (SGVFAA; EMT-B; Firefighter)
Curtis, MD, Jim (Pen Bay Medical Center; Emergency Physician)
Davis, Candy (SGVFAA; Paramedic, Ambulance Director)
Dougherty, Pat (South Thomaston Ambulance; EMT-I; Director)
Driscoll, Terence (Select Board Member)
Elwell, Randall (SGVFAA; Fire Captain)
Elwell, Tara (SGVFAA; President; Firefighter)
Fales, Dan (Citizens Advisory Group)
Falla, John (SGVFAA; Secretary/Treasurer; St. George Town Manager)
Ferguson, Chris (SGVFAA; Former Ambulance Director; EMT-I)
Field, Brian (SGVFAA; Former Ambulance Director; EMT-P)
Francavilla, Gill (SGVFAA; Driver)
Iliffe, William (SGVFAA; Fire Lieutenant)
Jarrett, Stephen (SGVFAA; Executive Committee; Firefighter)
Jordon, Charlie (Rockland Fire Department; Chief)
Judge, Tom (SGVFAA; Executive Committee; EMT-P)
Leavitt, Chris (SGVFAA; Fire Lieutenant)
Leo, Alan (as Maine EMS Licensing Agent; request for public information on licensing and actions as well as copies of documentation)
Leo, Alan (separate interview as Thomaston Ambulance Chief; EMT-P)
Lothrop, Linwood (Knox Regional Communications Center; Director)
Long, Patrick (Ashland Ambulance Service; Director)
Lunt, Donald (Select Board Member)
Mathieu, Mike (SGVFAA; AmeriCorps Volunteer; EMT)
May, Elizabeth (Citizens Advisory Group)
McIntosh, Ernest (Know County Sheriff's Department; Chief Deputy)
Miller, Anne (SGVFAA; Former Ambulance Director; RN; EMT-P (Ret.))
Miller, Keith (SGVFAA; Executive Committee; Fire Lieutenant)
Milton-Hall, Chris (SGVFAA; Driver)
Norman, Rich (South Thomaston Ambulance; Former Director; EMT-B)
Paine, Chuck (SGVFAA; Driver)
Polky, Catherine (SGVFAA; Fire Police; EMT-B)
Polky, Hildane (SGVFAA; Fire Captain; EMT-B)
Polky, RJ (SGVFAA; Firefighter; EMT-B)
Polky, Tim (SGVFAA; Fire Chief; EMT-B; Assistant Town Manager)
Pomelow, Kerry (Maine EMS Education Coordinator)
Prosser, Ellen (SGVFAA; Former Ambulance Director; EMT-I)
Powers, Jonathan (Maine EMS; Data Manager)
Rackliff, Dennis (SGVFAA; Assistant Fire Chief; First Responder (Ret.))
Randolph, MD, Whitney (through Bill Zito; Mid Coast EMS Medical Director)
Rassmussen, John (Citizens Advisory Group)
Reinhardt, Bill (SGVFAA; Fire Police)
Reinhardt, Bill (Select Board Member)
Robbins, Joanne (Northeast Harbor Ambulance Service; Director)
Shea, John (Citizens Advisory Group)
Smith, Linwood (Select Board Member)
Smith, Mike (SGVFAA; Vice-President; Former Ambulance Director; Deputy Fire Chief; EMT-B)
Walton, RN, Roxanne (Pen Bay Medical Center; ED Nurse Manager)
Zito, Bill (Mid Coast EMS; Executive Director)

From these sources, the historical and operating profile of the service in narrative and quantitative forms below were produced. Most of the work (e.g. the interviews) in this section provides material and background for reporting and recommendations in subsequent sections as well.

B. St. George Volunteer Firefighters and Ambulance Association in 2010: Capabilities and Performance

Mr. McGinnis:

- Inspected St. George Volunteer Firefighters and Ambulance Association EMS equipment, supplies, and facilities fully on one occasion and with a brief spot inspection on another occasion.

- Assessed dispatch capabilities through interviews.

- Interviewed key opinion-shapers and EMS leaders in this regard during the interviews described in the previous section.

- Reviewed:
  - Maine EMS licensing data;
  - Such licensing and operating/QI information that the Mid-Coast Regional EMS Council made available;
  - Such personnel and training records that SGVFAA made available;
  - Such budgetary and financial records SGVFAA made available;
  - Relevant operational policies and procedures (including dispatch), by-laws, surveys, municipal directives and authorizations, workplace safety and operating documents, forms, and records that SGVFAA made available;

- Performed an audit of 134 St. George Volunteer Firefighters and Ambulance Association patient/run records, for 2007, 2008, and 2009. Mr. McGinnis worked with the SGVFAA Ambulance Director to achieve an even distribution of calls over those years which was random and protected patient identity. These were copied and provided
by SGVFAA and have been shredded by Mr. McGinnis following the audit.

Governance, general operations, patient care, facilities and equipment, staffing, training, safety, budgeting/finance, and community relations/services components were evaluated using these sources and are reported below. A compilation of relevant licensing, operating, financial, personnel and other significant materials is also included in this report.


Mr. McGinnis provides a “strengths, weaknesses, opportunities, and threats” (“SWOT”) analysis and recommendations below, including the results of a SWOT exercise accomplished during the evaluation which employed the SGVFAA designated Project Working Group.

The report was delivered to the Steering and Executive Committees on June 30. Following a meeting between Kevin and the committee members on July 12th, additional copies were provided as they had agreed upon. Mr. McGinnis is available to present the report in any forum and to any audience specified by the SGVFAA.

IV. ASMI Consulting

ASMI is a Virginia-based association management firm that manages the National Association of State EMS Officials, the National Councils of State EMS Medical Directors, Training Coordinators, Data Managers, EMSC Coordinators and Trauma Managers. It also coordinates services for the International Association of Emergency Managers. It maintains an EMS consulting service whose principal consultant, Kevin McGinnis, assists communities and providers to assess their current EMS system capabilities and needs against contemporary standards. He then provides creative guidance in planning to meet those needs with 21st century excellence.

Mr. McGinnis is an independent EMS consultant, with 36 years of experience in EMS systems development. Former director of Maine EMS and Maine’s E-9-1-1 Program, he was inducted into the EMS Hall of Fame by Mid-Coast EMS in 2009 and received the Governor’s EMS Award from Governor King in 1997. He authored The Rural and Frontier EMS Agenda for the Future a 2004 milestone book for the federal government and the National Rural Health Association; and the 2009 book, EMS Officials Guide to Information Communications Technology.

Mr. McGinnis has been an ambulance service chief of paid and volunteer ambulance services in two states, and has significant working experience with urban, suburban, and
rural fire rescue/first responder, and ambulance services. An emergency department and regional EMS director, and past chair of two national EMS organizations, Kevin has served as a consultant to governments on the local, state, and national levels. He has had experience as a member of, liaison to, or staffing a dozen regional EMS councils, and is responsible for having initiated or helped to develop regional and statewide EMS plans, protocols, QA/QI ASMI, run record data ASMI, and policies in three states.

Kevin has undergraduate and graduate degrees in hospital and health care delivery systems planning and administration, and holds or has held a variety of EMS clinical and instructor certifications. He has practiced as an EMT or paramedic throughout his career.

Mr. McGinnis has participated as principal consultant, or on federal consulting teams for state or local EMS system evaluations in Arkansas, Alabama, South Dakota, New York and Montana. As a state and regional EMS director, and private contractor, he has evaluated and assisted EMS operations of most types. He has completed service assessments and strategic planning projects in several Maine communities.

V. Findings and Recommendations

A. St. George Volunteer Firefighters and Ambulance Association in 2010: What It Is & Where It Came From

Background – EMS

“Emergency medical services” or “EMS” did not exist in name or concept much before the mid-sixties in the United States. Before the birth of EMS in the late 1960’s and early 1970’s, ambulance service was primarily transportation and not medical care. This service was usually performed in more rural areas as a secondary service by a business with a vehicle that could serve as a “horizontal taxicab” such as a funeral home (hearse) or fire department (rescue/equipment truck or chief’s station wagon).

Federal studies and legislation occurring between 1966 and 1972 called for a system of emergency medical services nationwide with improved equipment and training, better communications and medical direction between ambulance crews and hospitals, and licensing of EMS providers by states. This modernization forced many ambulance service providers out of business. No longer was ambulance service a convenient and inexpensive secondary business or community service. Providing a community’s EMS soon became a significant responsibility requiring the investment of considerable time and money.

Today, the highest level of routine Emergency Medical Services response in Maine and in the United States is a crew consisting of at least one Emergency Medical Technician licensed at the Paramedic level and at least one other Emergency Medical Technician licensed at the Basic, Intermediate or Paramedic (EMT-B, EMT-I, EMT-P) levels.
Paramedics (EMT-Ps) have undergone in excess of 1,000 hours of training over a minimum of two years’ time, not including actual field-practice experience gained during training and while advancing from the Basic EMT (EMT-B) level. Paramedics are able to manage most injury and illness emergencies utilizing a variety of advanced patient assessment and treatment techniques primarily utilized in emergency departments. They employ tools such as cardiac monitoring and electrical intervention (three and twelve lead ECG, defibrillation, synchronized cardioversion, defibrillation, pacing), medications (cardiac, respiratory, allergic/diabetic reactions, and seizures for example), and surgical procedures.

Intermediate EMTs (EMT-Is) are the licensure step between Basic EMTs and Paramedics. With 280 hours of training in addition to their EMT-Basic training, they can provide some advanced skills of the Paramedic such as establishing intravenous (IV) lines for fluid replacement and medication administration, placing advanced airways, and doing some cardiac monitoring and defibrillation. EMT-Intermediates in recent years have gained the ability to administer certain life-saving medications as well.

Basic EMTs (EMT-Bs) have approximately 118 to 135 hours of training. They provide basic life support assessment and treatments such as CPR, oxygen administration, automatic defibrillation, splinting and bleeding control, spinal immobilization, patient extrication/lifting/moving, and basic management of trauma and illness patients. They too have been given the ability to administer or assist with certain life-saving medications.

**Background – Rural EMS and EMS in Maine**

“Paradox” means “contradiction” (especially something that contradicts itself) or “puzzle”. Rural EMS involves a frustrating, but perpetually unresolved, paradox. In rural areas, where the most advanced EMS capability is most needed, it is least afforded.

Because of longer distances to the nearest emergency care facilities (20 to 45 minutes versus a more urban/suburban area’s 5 to 15 minutes), the highest possible level of EMS is *really* needed to stabilize critical patients to survive these long transports. More and more frequently, if the patients cannot be revived in the field, they are not even *being* transported to the hospital.

This highest possible level of EMS patient care (Paramedic) requires expensive equipment and EMS personnel who are highly skilled and maintain their skills through constant use. Paradoxically, these same rural areas have populations and tax bases that are usually too thin to support the expense involved and EMS call volumes too low to maintain complex skills.

In urban areas, the standard of response is generally held as basic life support (First Responders/EMT-Bs/EMT-Is) within four minutes and full advanced life support
(Paramedics) within eight to ten minutes of the emergency call. This is based on the need for rapid intervention when a patient’s heart or breathing stops.

In rural areas, it is recognized that this standard is impractical. Maine EMS requires that services maintain an average response time of no more than twenty minutes, while the state average hovers around eight minutes from year to year (Maine’s “urban/suburban” areas tend to meet the four minute/eight minute national standard). Rural ambulance services in Maine generally maintain annual average response times in the seven to fifteen minute range.

Given this, these services often encourage licensed First Responders or Emergency Medical Technicians to be available throughout a response area to go to the scene of an emergency to provide life-saving basic care until the ambulance arrives. These additional crew members are also vital in providing extra hands for complex situations (e.g. cardiac arrest, extrication from crashed vehicles) and the lifting and moving of patients – functions often performed in urban areas by law enforcement or fire personnel who are immediately on the scene, or by bystanders who are plentiful.

Rural areas, in particular, have relied heavily on volunteers and charitable donations to establish and maintain ambulance and first responder EMS. As EMS has increased its capabilities and has become more complex, and as the public expectation of EMS has increased through exposure to popular television and other media, it has become very difficult to maintain purely volunteer ambulance services.

It is, for example, very hard to cultivate individuals with the talent and dedication to go through the extensive training required of Paramedics and to expect them to provide that patient service on a volunteer basis. Further, it is questionable whether a Paramedic can maintain the skill set required to be effective when they employ those skills only on an infrequent basis.

Yet the public’s expectation, as a Maine EMS scientific poll strongly indicated, is that Paramedic type care will be provided when it is needed. For patients and their relatives exposed to years of “Rescue 9-1-1”, “Emergency”, “ER”, and other media treatment of EMS, an EMS agency offers lesser levels of emergency care at increasing risk.

In some of the suburban/rural areas of the state, this expectation is being met by services that hire Paramedics to supplement volunteer personnel (as well as weekday daytime EMT drivers, a function which has been increasingly difficult to assure through volunteer means over the past twenty years). Some areas which have had paid crews for many years, have relied upon relatively low pay scales, call pay for “second unit out” backup, and other devices to keep costs low. In yet other similar areas, services depend on their neighbors for Paramedic back-up. In rural areas of Maine, where there are no practical neighboring services, towns and health care facilities are increasingly being called upon to pay for Paramedic level service.
As a service experiences the transition from volunteer and part-time to partially paid with some full-time to accommodate the need for reliably available Paramedics and weekday drivers, severe stresses are placed on the service. The largely social character of the former all-volunteer, or lesser paid organization is increasingly displaced by expectations on the organization that it be financially, operationally, and clinically accountable to those (town or hospital officials) providing the funds to provide Paramedic level care and to those (State/Regional EMS system officials) authorizing provision of care at this level.

Because of the increasing complexity of managing a rural service and because chiefs of rural services frequently do not take on the role with prior management experience, Maine EMS sponsors training programs for such managers from time to time. Nationally, The National EMS Management Association (NEMSMA) and the National Fire Academy offer support resources and/or courses for EMS managers.

Continued dependence on volunteers or a large contingent of call pay personnel (necessary in rural areas) requires one set of personnel recruitment and retention skills different from those required to be effective with a largely full-time paid staff. However, this type of service has the same legal, workplace safety, clinical, quality assurance, public relations, billing, and other management requirements that fully paid urban services do. The management requirements of a rural service operating at the Paramedic level in 2010 are more complex than ever.

Services such as these require management systems to support the ambulance service manager in implementing human resources, financial, operating policy and procedure, quality assurance and other administrative processes to meet organizational and accountability expectations. Unfortunately, federal and state reimbursement systems, and other third party payers do not provide cost-based financial support of such services. Small-volume EMS services must find other ways than reliance on per-call based revenue to implement Paramedic care and professional management systems. Such improvements are often found through consolidation with organizations already having most of the necessary administrative/bureaucratic components such as local government, hospital, or existing commercial or non-profit ambulance services. Other EMS services must expand their territory and/or seek governmental subsidy to survive.

**EMS in St. George**
The previous background sections ring true for EMS development in the St. George area with one notable exception: while most other volunteer services in Maine have gone through the transition to paying staff and charging patients, the SGVFAA ambulance service has maintained its purely volunteer and non-billing status.

The service’s roots lie in the St. George Volunteer Firemen’s Association, begun in 1953, some ten years after the first fire truck came to town as a part of a Civil Defense initiative and the first firefighters received their training in Rockland. “From its origins, the ambulance service was a fully volunteer service entirely funded by community donations. The first ambulance was purchased with funds raised by a house-to-house
canvas by the Fireman’s Association. A total of $308.00 was raised in that effort. At the
time the ambulance was purchased there were approximately 35 volunteers.” (SGVFAA
website http://sites.google.com/site/stgeorgeambulance/home. Thanks to long-time
Association member, William Reinhardt, Chris Milton-Hall, and Charme Blaisdell for
historical research and sources.)

The early, station wagon ambulances were difficult to work in and many services were
content to let them serve as horizontal taxicabs. But also characteristic of the St. George
EMS spirit, the early ambulance members purchased resuscitators and other emergency
medical treatment equipment and sought out first aid training and then, when the State
first required more formal preparation and certification of service and personnel
capabilities, took the earliest version of Basic EMT training in the early 1970’s.

The Ambulance Service continued to mature, with advanced life support training and
equipment adopted, and newer ambulances purchased and replaced to maintain a high
quality service. In 1990, the Association was formally incorporated as 501 (c) 3 known
as the St. George Volunteer Firefighters and Ambulance Association. The Ambulance
Service began to offer Paramedic level service with a group of very active volunteers
whose employers were very generous in allowing them time to respond from work to
calls. The combination of a very dedicated, true team of volunteer drivers, EMTs, and
Paramedics, and extensive community support produced a service that has enjoyed a
region-wide reputation of excellence to this day.

Unfortunately, the SGVFAA Ambulance Service has experienced in recent years, and
particularly in recent months, the turmoil that has caused other volunteer services to
transition away from the traditional, purely volunteer approach. Bickering within the
ranks threatens the team quality of the service. The ability to respond effectively on all
calls with adequate personnel and to provide advanced life support (ALS) without
reliance on neighboring services is compromised by personnel availability lapses. When
neighboring services respond, they charge the service and patients who are transported by
them, and ALS may be delayed. These issues have led to increasing debate about the
need to implement a pay system and to use town funding and/or patient billing to support
the increased expenses which would result.

There is fierce devotion among some to the volunteer, non-charging current structure
while others reluctantly or optimistically believe that these changes are inevitable. There
have also been informal discussions about developing a more regional approach with
neighboring services to better assure response, while others believe that recent school regionalization, and personality and inter-community conflicts would make this difficult. Discussions on regionalization have taken place previously with neighboring service, but have not suggested a potentially successful model.

**The St. George Operating Picture and Comparison Services**

In this section, the operational picture of the SGVFAA Ambulance Service is presented through the eye of the Maine EMS data system, supplemented with other information received or generated during this evaluation. The Maine EMS data is derived from the patient care/run records (PCRs) that are completed for the responses the ambulance makes, whether patients are treated and transported or not.

In addition, we will look at the same numbers for two comparison services. This is of interest mainly because of the half dozen candidate comparison services considered (based on similarity of call volume and community setting) these two have very similar roots to the St. George service, but have elected to adopt some of the operating tools being discussed in St. George (e.g. incentive pay, patient billing). While this exercise may be instructive, it must be consumed cautiously to avoid inaccurate conclusions based on apples-to-oranges comparisons.

The comparison services are the Ashland Ambulance in Aroostook County, and the Northeast Harbor Ambulance Service (NHAS) on Mt. Desert Island. Both services came from similar volunteer histories as the SGVFAA Ambulance, are independent from the fire departments in which they are housed (but operate well with, and share members with those departments), and serve relatively isolated, rural communities. Northeast Harbor has a significant summer community with wealthy residents while Ashland serves a large response area that includes recreational tourism, logging and farming industries.

Both comparison services are licensed at the Basic level with permits to Paramedic, like St. George. As in St. George, the ambulance garages of the comparison services are not staffed. NHAS does not use a schedule while SGVFAA Ambulance has partially implemented a schedule. Northeast Harbor depends on neighboring services for ALS coverage about 30% of the time. St. George has averaged a lower mutual aid rate, but this varies and will be discussed later. Members of both NHAS and St. George are allowed to respond from wherever they are at the moment. Ashland does use a schedule, and members must stay within three minutes of the ambulance garage when they are scheduled on duty. ALS back-up is rarely needed.

Both comparison services have adopted systems of paying staff. NHAS provides call pay incentives that range from $10 to $20 an hour, with a two hour minimum per call (one hour if a member just assists at the scene and does not go to the hospital). Paramedics at NHAS receive a bonus of one extra hour of pay for every four hours worked, paid on a quarterly basis. NHAS staff members are paid to do weekly ambulance mechanical and medical equipment and supplies inspections. The staff member responsible is paid an
extra hour if they come back to base to complete their electronic run record so that others can get back to their routines. The NHAS annual expense budget was $109,700 in 2009.

Ashland employs a full-time ambulance director at an hourly pay rate with overtime and benefits. It also employs a second full-time paramedic on the same pay basis. When these paramedics are not available, it pay on-call paramedics, generally from Crown Ambulance in Presque Isle, $15/hour for a 24 hour shift in town. Local crew members receive one to two dollars per hour to be scheduled on call. They then receive from approximately $8 to $10 an hour when they are responding on calls. The Ashland annual expense budget is $127,700.

NHAS does bill patients and also does significant fundraising, similar to St. George (its annual appeal recently generated $60,000, double that of a few years ago; a “Tulip Tour” of one resident’s gardens over two weekends netted $11,000; and a special purpose appeal to buy a new ambulance paid for 75% of the cost, with one resident donating $50,000). The revenues from fundraising and patient billing each support approximately half of NHAS’ expenses each year. They firmly believe that patient billing has not compromised the success of fund-raising. They pay Marion Dennis of Blue Hill, who does billing for a number of services, $200 per month.

Ashland also bills patients. It does not actively do fundraising. The service receives subsidies from the towns that it serves outside of Ashland (based on property valuations) and is supported as an Ashland Town line item (from which it makes up deficits each year if subsidies and billings do not suffice to meet expenses). Approximately 50% of the revenue comes from town subsidies, 40% from patient billing and 10% from the Town of Ashland. The ambulance director does the billing and estimates that it costs (beyond the cost of his pay) $.03/patient billed.

### 1999 Operations

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<th>Service</th>
<th>Emergency Transports</th>
<th>Routine Transfers</th>
<th>All No Transports</th>
<th>*Average Response Time (mins.)</th>
<th>% 9 Minutes or More**</th>
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<tr>
<td>Ashland</td>
<td>173 (89%)</td>
<td>6 (3%)</td>
<td>15 (8%)</td>
<td>10</td>
<td>53%</td>
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<td>NHAS</td>
<td>179 (79%)</td>
<td>31 (14%)</td>
<td>16 (7%)</td>
<td>9</td>
<td>47%</td>
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<tr>
<td>SGVFAA</td>
<td>130 (81%)</td>
<td>9 (6%)</td>
<td>22 (13%)</td>
<td>10</td>
<td>54%</td>
</tr>
</tbody>
</table>

* State average – 8 minutes; ** State average – 34%

### 2004 Operations

<table>
<thead>
<tr>
<th>Service</th>
<th>Emergency Transports</th>
<th>Routine Transfers</th>
<th>No Transports</th>
<th>*Average Response Time (mins.)</th>
<th>% 9 Minutes or More**</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ashland</td>
<td>149 (81%)</td>
<td>6 (3%)</td>
<td>29 (16%)</td>
<td>10</td>
<td>50%</td>
</tr>
<tr>
<td>NHAS</td>
<td>144 (79%)</td>
<td>19 (10%)</td>
<td>21 (11%)</td>
<td>11</td>
<td>61%</td>
</tr>
<tr>
<td>SGVFAA</td>
<td>150 (84%)</td>
<td>2 (1%)</td>
<td>27 (15%)</td>
<td>10</td>
<td>63%</td>
</tr>
</tbody>
</table>

* State average – 7 minutes; ** State average – 34%
**2009 Operations** – state averages not available

<table>
<thead>
<tr>
<th>Service</th>
<th>Emergency Transports</th>
<th>“Chute” Time</th>
<th>No Transports</th>
<th>Average Response Time (mins.)</th>
<th>% 9 Minutes or More</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ashland</td>
<td>165 (90%)</td>
<td>4 min; 7% &gt; 5 min</td>
<td>17 (10%)</td>
<td>11</td>
<td>28%</td>
</tr>
<tr>
<td>NHAS</td>
<td>192 (81%)</td>
<td>8 min; 21% &gt; 5 min</td>
<td>46 (19%)</td>
<td>18</td>
<td>79%</td>
</tr>
<tr>
<td>SGVFAA</td>
<td>141 (92%)</td>
<td>10 min; 84% &gt; 5 min</td>
<td>13 (8%)</td>
<td>16</td>
<td>86%</td>
</tr>
</tbody>
</table>

All three services have gone up and down in total volume which is unremarkable. In fact, there are no remarkable differences among the services in the 1999 figures and five years later. The “No Transports” percentages can get up into the 20-30% range when a service is doing a lot of “treat and release” calls which are more common in rural areas, but we don’t see that with these services. The Routine Transfer activity is insignificant in 1999 through 2004 and was not tracked in 2009 for these services (Ashland has begun to do transfers, while the other services generally do not).

The change in the percentage of response times longer than 9 minutes for all three services from 2004 to 2009 is remarkable but may be a result of how times are recorded in the new electronic run record system. Ashland’s use of paid providers and its rule that responders on duty must be within three minutes of the ambulance garage could explain its response improvement. Unavailable until the electronic PCR system, “Chute Time” (time from dispatch call to vehicle response from garage) is interesting in 2009. St. George has ten minute chute times with NHAS performing somewhat better, and Ashland performing best. It is not unreasonable to attribute these figures to pay, scheduling and staffing policies.

While researching this data, it was found in interviews that different interpretations of “arrived at scene” are held by some SGVAA Ambulance Service members. Some interpret that when individual responders are going directly to the scene and arrive ahead of the ambulance that their arrival is used as the service’s “arrived at scene” time.

**Finding:** If this is how St. George determines “arrived at scene”, it creates a discrepancy with the National EMS Information System (NEMSIS) definition upon which the Maine EMS run record system software is based. The intent is that “arrived at scene” is the time at which the equipped vehicle and crew are first all at the scene together. This is a problem if:

- St. George wants to be able to compare its performance with other ambulance services.
- Leadership allows “arrived at scene” to sometimes be the ambulance arrival time and sometimes be the first responder arrival time. If a definition is used which reflects that a St. George EMT-B or higher crew member has arrived at scene
(whether in the ambulance or not) this is at least consistent internally to the service. Documentation has to be excellent, however, to explain why the service apparently arrived at the scene (when it is just a responder with a personal kit) and certain procedures (defibrillation, medications, etc.) were not performed until significantly later (when the ambulance arrives with the equipment and supplies necessary to perform them).

Recommendation: “Arrived at scene” is an indicator that the service, not an individual or individual component (like the ambulance with a non-medical driver only) is at the scene. This can be difficult to get right with a volunteer service that arrives at the scene “in pieces”, and this is not a St. George issue alone. For consistency and comparability sake, it would be best to enforce an “arrived at scene” time that reflects when the ambulance and at least a basic EMT (the service’s licensed response level) is at the scene together. If this cannot be achieved, then a standard should be enforced that at least provides consistency within the service for year to year comparisons against its own performance.

The 2009 data summaries for the three services otherwise show similar call profiles which do not bear comment here, but are attached for reference as an appendix. Certainly information about the occurrence of calls by time of day and day of week, as well as about types of calls by condition dispatched or provider impression, have potential to instruct staff scheduling and training if used as a part of a consistent and well-managed quality improvement (QI) program.

There are obvious problems with some of these reports which are testimony to the switch to the new electronic run record system. The reader is urged to review and use these data critically. These data, while suggestive, are not being used to make findings or recommendations as a result.

While the comparison of these services shows some impact of the differences between a service that pays people to be on call within three minutes of the station and services that rely on unscheduled personnel with no such restrictions, it is a sizable budgetary (employing patient billing and subsidies in place of fund-raising) and operational leap to go from one to the other. And while it is less of a leap to go from unscheduled and unpaid to incentive pay with no duty schedule or response requirement as NHAS has done, we see far less impact on response capability. In fact, NHAS leaders interviewed feel that their staffing is fairly steady, they need no active recruiting, and incentive pay has not made that much of a difference. The Ashland ambulance director says that the service has had the same roster size for years and that pay hasn’t made a difference except in assuring the presence of paramedics. Ashland does no active recruiting except for the medic positions. The director admits that on-call pay and call pay, as well as paying paramedics, does allow for the response requirement and the reliability of a fast staff response.
B. St. George Volunteer Firefighters and Ambulance Association in 2010: Capabilities and Performance

Governance
The Ambulance Service is governed by the St. George Volunteer Firefighters and Ambulance Association as described by its “Constitution and By-Laws” as amended and effective June 9, 1999. An articles of incorporation was also reviewed and is essentially consistent with the by-laws.

The Association’s purpose, according to the by-laws document, is “to promote and provide for the development of a structure for the delivery and operation of a trained firefighting and emergency medical service in the Town of St. George….to determine the need for firefighting and emergency medical service in the Town of St. George and to administer and determine the priority of expenditures …in order to most effectively meet those needs; to provide coordinated training and operational activities for said corporation; to generally promote and advance the interests of the general public in the delivery of firefighting and emergency medical services in the Town of St. George.”

In summary, the Association’s formal purview is to:
1. Determine the need for fire and EMS services;
2. Administer and determine the priority of expenditures to meet those needs;
3. “Promote and provide for” a structure to deliver fire and EMS services;
4. Provide training and operational “activities” for “said corporation”; and
5. Promote and advance the interests of the general public

The Constitution and By-Laws document defines, in detail, Association membership status and processes for becoming, remaining, and being discharged as a member; as well as meeting and officer functional duties and processes by which they are carried out.

The document has two references to the Association’s potential operational responsibilities for the Ambulance Service. First, it names the Ambulance Director as one of the officers of the Association whose duties “include overseeing the general operation and maintenance of the ambulance and the training and licensing of ambulance personnel”. Second, and less clearly operational, is the Executive Committee (consisting of the officers of the Association and three other elected members) whose responsibility is to make recommendations to the membership on “planning and financial matters” and “to assist in preparation of the proposed budget for the coming year”.

The reality of the Association is that would-be responders become members of the Association to become active on the Ambulance Service or Fire department (though the by-laws do not appear to require this). The Association has monthly and annual meetings which appear to be used for decision-making in carrying out the five areas of purview described above, and in considering recommendations from the Executive Committee. The Association votes slates of fire officers each year as recommendations to the Town’s Select Board because the Town operates the Fire Department. The Association elects the
Ambulance Director and Association’s Executive Committee (officers plus three additional members). The Association conducts fund-raising activities. It seems to be widely interpreted that the Association has final say in Ambulance Service operational matters, such as the purchase of equipment and the adoption of policies and procedures.

Members interviewed had widely differing views of the roles of the officers, Executive Committee, and membership. There seemed to be consensus that there is great room for improvement in organizational structure and specifically for a more effective and efficient organization.

A substantial majority of those interviewed believed that the Ambulance Service should be maintained as a private, independent organization and not a part of the town structure. Cited were the complications of operating within a government bureaucracy and the potential difficulty of recruiting volunteers into a municipal service. A few, including some Executive Committee members, believed that having the Service become a Town service would qualify it for more secure funding under the tax base and afford it better organization in a more streamlined decision-making process than the Association allows.

**Finding:** The by-laws document is vague and needs to be rewritten. These by-laws do not provide for, nor does the Association practice, a logical governance structure. The responsibilities assigned by the by-laws give great latitude, which in itself is not a bad thing, but they do not seem to reflect what the Association does month in and month out. The by-laws can probably be rewritten within the scope of the current articles of incorporation, not necessitating their revision, though an attorney ought to be consulted. The modern Ambulance Service, whether volunteer or paid, has a complex set of operational and clinical responsibilities. It must be efficient, effective, and responsive to changing needs, and therefore run as a well-oiled business. The by-laws do not support this kind of operational decision-making. Further, the perception that all decisions must be made by the Association bogs down decision-making and creates strife and bickering at and between Association meetings, and is a part of a persisting and destructive power and personality conflict issue. The Ambulance Service should be recognized, by virtue of its complexity beyond that of a simple transport service and by virtue of its call volume, as an EMS agency of equal standing to its Fire Department colleague. Given this, the EMS/Fire/Rescue team integration that works so well on scenes should not be compromised by any less of a sharing and cross-training of members or coordination of training and planning activities than in the past. The independent Association should be preserved. The Citizen Advisory Committee is a unique and potentially very beneficial support group for the Service and for the Executive Committee in carrying out its charges.

**Recommendation:** The by-laws should be changed to:

- Affirm the continued operation of the Ambulance Service (as “St. George EMS”) as a private, independent organization.
- Enable a St. George EMS/Fire/Rescue Association with clearly defined responsibilities which reflect the actual practices that the present Association
members today wish to carry out. Recommending slates of fire officers, conducting fund-raising activities, planning for the Ambulance Service, approving expenditures of a certain level are among activities currently done which should be spelled out (e.g. the draft purchasing policy now under consideration should be referred to in the by-laws, giving the Association the flexibility to change the policy without a by-laws change);

- Continue to give the Association the responsibility to elect the Executive Committee (except for a Citizen Advisory Committee member and EMS Chief, as described below);
- Specify the voting rights of the Executive Committee members (note: at the July 12th Project Working Group/Executive Committee meeting to review this report, it was suggested that “Executive Committee” be changed to “Board of Directors”. Upon review of the articles of incorporation, there is mention already of a board of directors with a different definition. The “Executive Committee” should be retained as such.);
- Rename the Ambulance Director as EMS Chief;
- Remove the EMS Chief as a voting member of the Executive Committee, but specify that the EMS Chief will participate as a non-voting, ex-officio (i.e. by virtue of the position) member of that Committee;
- Establish one three year seat on the Executive Committee to be named by the Citizens Advisory Group/Committee;
- Specify that the Executive Committee will be responsible for hiring and terminating the EMS Chief and will be responsible for the month to month coordination of fund-raising, planning, approval of expenses over a certain level, and approval of certain major activities which do not constitute day to day administrative and clinical operations. The Committee should meet on a monthly or every other month schedule as needed, and should be available for special meetings at the request of the EMS Chief and/or President.
- Specify that the EMS Chief will be hired based on his or her merits and potential to successfully lead and manage the Service, and will be given sole responsibility for hiring and terminating staff and for naming EMS officers to positions approved by the Executive Committee. The EMS Chief and his or her officers should have sole day to day administrative and clinical operations of the St. George EMS.
- Provide the EMS Chief with management support services to include, at least: membership in the National EMS Management Association, participation in the North Central EMS Institute, participation in Maine EMS management training courses, and membership in the Maine Ambulance Association.
- Specify that responders hired by the EMS and Fire Chiefs do not have to be Association members and should have residency and other hiring restrictions imposed only as defined in policy by those Chiefs.
Licensed Capabilities, Equipment and Facilities

License applications for the past ten years were reviewed and found to be generally in order, though newer applications do not list Quality Assurance Committee members. The SGVFAA service holds Maine EMS state ambulance service license 605. Until its expiration in August, 2010 when it is eligible for renewal. The service is licensed at the EMT-Basic level, which is the level of provider that must be present on every call, with a permit to the Paramedic level, which is the level at which it may perform when a higher level licensee is present. In 2004 and 2005, the Service applied for EMT-Paramedic licenses and reverted to EMT-Basic licenses in 2006, where it has remained.

Until this information was no longer requested in the licensing process, the Service listed a primary response area as St. George and surrounding islands, and secondary response area of Knox County for mutual aid.

The St. George Junior EMT policy was approved initially in 2002, and revised in 2009. It is on file at Maine EMS. Also on file at Maine EMS are an SGVFAA Service Quality Assurance (QA) Plan which is 10 years old, a drug box agreement with Pen Bay which is 15 years old, and out-of-drug-box drug agreement with Pen Bay which is 10 years old.

Finding: St. George leaders clearly recognize the importance of Quality Improvement/Quality Assurance (QI/QA) as they devote one of two EMS meetings a month to it. A recent suggestion to eliminate that meeting, or to cut the two meetings to one and share QI/QA and training in one meeting, was unpopular among the general crew as well. Motivation is not the issue here the crew and leaders want to improve what they do for patients. Yet, many interviewed saw QI/QA as run-record editing only or attacks on individual providers in a case review process. One explanation spread for this was that QA discussions might violate “confidentiality law”. To the contrary, Maine EMS has built into the EMS law protections to encourage just these discussions (see the wording in the license application form attached in the appendices). None of what was described by anybody in interviews resembles what the service is on record at Maine EMS as agreeing to provide for QI/QA. Proper QI/QA must be accomplished carefully and unthreateningly by a trained individual. It should also be closely linked to the Service’s training program and the development of Service policies and procedures. A volunteer, stipended EMS Chief would be very hard-pressed to carry out all of these responsibilities successfully alone.

Recommendation: The QA and drug box plans on file at Maine EMS (and in the appendices of this report) should be reviewed and updated so that they reflect current practice. Maine EMS is reviewing and updating its QA requirements so this should be done as the new requirements become evident.

Recommendation: The QA/QI process should be developed to benchmark and clearly link service performance with training and education solutions and, less often, with changes in policy and procedures. The emphasis should be on the service and its patient
care system, and not on individual performances as a group matter (QI/QA is never a roast). Auditing runs using the “EMS story-telling gold measure” described below for individual feedback is appropriate, but is not all that QI/QA should provide. Accomplishing this successfully will require two stipended QI/Training Officers (a primary and an assistant). There are recommendations below on the development of a command structure.

The service holds Maine EMS licenses for two ambulance vehicles:

- **Rescue 1** - A 1994 Ford chassis, Wheeled Coach Type III (walkthrough, box) conversion, with VIN# 75880, and holding Maine DMV plate 1786 and Maine EMS license # 857.
- **Rescue 2** – A 2004 Ford Chassis, PL Custom Type III (walkthrough, box) conversion, with VIN# 54988, and holding Maine DMV plate 2516 and Maine EMS license # 1409.

The most recent Maine EMS ambulance inspections, completed in July, 2008, show no deficiencies and “clean…well-stocked…and maintained” vehicles. Inspections dating back to 2000 show no major deficiencies and always reflect well-stocked and maintained vehicles. On at least two occasions, deficiencies in weekly sign-offs of drug box records were noted.

Maine EMS inspections are announced in advance. For the purpose of this study, two vehicle and premises inspections were held. Neither were announced. One was thorough, with the Ambulance Director and one member present. The second was a brief spot check following meetings in the Town office and with no members present.

The ambulance garage was clean and uncluttered on all occasions when viewed. On the occasions of the inspections, the garage was found to be more than adequate for the purpose of housing the ambulance vehicles. It has contemporary safety and health features such as an exhaust venting system for all vehicles, and separate cleaning and decontamination facilities. Because the Fire Department and Ambulance Service are run by different public and private entities (the Town and Association respectively), each is subject to enforcement and inspection by either the State Bureau of Labor Standards (fire) or the Federal Occupational Safety and Health Administration (OSHA – ambulance).

There is a meeting hall that adequately serves training and meeting needs, including an equipped kitchen. There is office space dedicated to the ambulance, with locked units for personnel records and ambulance run records. No protected information was in evidence during visits to those offices.

**Finding:** The ambulance facility is superior to those of many small services with this call volume, and speaks to the motivation of the Association’s members and the support of the Town and its citizens.
The ambulances are stored one behind the other which could make it difficult to extricate the rearward vehicle if the first vehicle failed to start during a call. In perspective, a lot of services of this size don’t have a second ambulance should the first fail to start. It is a minor observation that storing the ambulances in separate quarters would resolve this issue and perhaps provide an option in response given the location of the call. To do so may also raise restocking and other issues, but may be a consideration in future planning.

The only problems noted in the garage area were a collection of old oxygen cylinders with old regulators that were either beyond their static testing dates or unmarked, and somewhat cluttered supply cabinets with some supplies that looked old though bore no expiration dates.

The vehicles were found to be clean, generously stocked, and well-maintained on both inspections. Rescue 1 is a 1994 with 64,592 miles at the time of inspection. It has no evidence of impending need to be replaced although at this mileage, and especially age, that may become a consideration. Vehicles produced in the past twenty years have proven to last longer than previously experienced when ambulances were commonly traded away at about this mileage. Age and working in a salt air community in Maine, may become a bigger factor in its demise than its mileage. The Service is therefore commended on its vehicle replacement fund and eye to the future. Rescue 2 is a 2004 with 31,041 miles at the time of inspection (and 1884 hours). It appears in fine shape.

A number of those interviewed cited frustration with crew members failing to restock, clean, and assure replacement of critical supplies such as oxygen after calls. Others did not encounter such issues. I found no evidence of critical equipment being dysfunctional or supplies such as oxygen being in inadequate supply. The drug box and out of drug box records appeared to be up to date. Members were generally happy with the equipment and supplies available for patient care.

The inspections did find:

- Saline syringes 2 years out of date.
- ET tubes out of date or in yellowed packages with no expiration dates.
- Yellowing extension sets (no expiration dates) in an ALS kit.
- A cricothyrotomy kit expired since 2008.
- A chest decompression kit with expired needles.
- Pediatric ET tubes expired.
- An open cricothyrotomy kit.
- Medical histories of members for rehab purposes stored in vehicle, and accessible.
- 4x4s and other supply packaging yellowed and obviously old.
- Overstocks of IVs and supplies, ET equipment and supplies, and many other types of bandaging and other supplies.
- An inventory record form is maintained, with inventory reportedly done on the last Wednesday of the month. The inventory form reflects Maine EMS rules minimums, but does not include many items actually carried.
Finding: The issues of old and expired items, and of overstocks of items (which in a low call volume service leads to more old and expired items being present) are not uncommon in small, volunteer services with slow inventory turnover and where members do not staff the base and have idle time to inventory. The items mentioned were likely not patient care threats, and other supplies were in abundance if an expired item was discarded during a call.

Recommendation: Establish a more frequent inventory schedule than once a month. Establish inventory levels that are reasonable to last from one scheduled inventory to another, with enough extra inventory that the Service’s officers are comfortable. Extra inventory is required for periods of extra activity and unusual events, but amounts must be established in a thought-out process by experienced Service members. Most of the overstock that is now carried reflects many people making informal, one person decisions about adding items based on their own experience or intuition. This “too many chefs” approach inevitably results in overstocking, expirations, and waste. Once inventory levels are approved, create an inventory form that reflects those levels.

Finding: Responsibility for overseeing vehicle maintenance, medical equipment maintenance, and maintaining adequate supply inventories is the responsibility of the crew after calls, and regular but infrequent or ad hoc inspections and documentation processes by volunteers. There is no reliable step of accountability apparent between that level and the Ambulance Director. These vehicles are expected to perform optimally every other day on average. Other than the volunteer resource involved in making the Ambulance Service successful, the vehicles and their equipment and supplies are the most relied upon resources during calls. More oversight is required.

Recommendation: Establish stipended officer positions (primary and assistant) to oversee these aspects of the operation. They should also be in charge of assuring the training and approval of vehicle drivers. There are recommendations below on the development of a command structure.

Patient Care, Staffing, and Documentation

Patient Care
Local and regional emergency physician, medical direction, nursing and system coordination staff, as well as most officials from neighboring services laud the quality of care provided over the years by the St. George Ambulance team. All consulted at Pen Bay Medical Center as surveyed by the nurse manager expressed respect for the quality of care, the motivation and teamwork of the staff, and the renowned community support of the Service. The most negative thing mentioned was that some could work on IV skills. There is an awareness by neighboring services that Paramedics on the service are not as available as they once were and that ALS mutual aid requests have increased over the years.

The PCR audit, on the whole, found patient care to be appropriate. The consultant will discuss specific issues with the EMS Chief as requested. The only patterns that should be
addressed are the use of oxygen and IVs. There is a seeming preponderance of nasal cannula (NC) use for oxygen delivery. There is both NC oxygen delivery for patients who do not seem to need oxygen and NC delivery for those who need lots of oxygen. While medical opinions and protocols vary, this pattern should be reviewed. There also seems to be some use of IVs for patients who do not require fluid supplementation or a medical access route. Again, appropriate precautionary IVs may be being placed without adequate explanation, but this bears review.

**Finding:** With only an exception or two, out of over 50 people interviewed, there were no members or others who would not welcome a St. George response to their emergency. An audit found patient care to be reasonably sound. There is no service medical director, but these are not easy to find in the State. The Service would benefit from the service of a medical director in combination and working with a QI/QA process, as previously described.

**Recommendation:** Seek a medical director employing the lure of an officer title, a uniform, faster community acceptance and, if necessary, a stipend. Have him or her work with the officers in charge of quality improvement to design that program.

**Staffing**
The volunteer tradition is stronger in some areas of the country than others. In at least one state evaluated by the consultant, volunteer services with one to three hour response times were tolerated as were volunteer rescue squads who could only answer 10% of their calls, deferring to a regional service for the rest. In two other states with which he is familiar, the EMS laws have forbidden any regulations to be placed on volunteer services with standards for equipment, training or patient care. In his experience in Maine, the attitude of volunteers has been to want to be held to the same standards as those who are paid, thus the Maine EMS insistence in the past on the phrase “paid and volunteer EMS professionals”.

The St. George VFAA Ambulance Service in the past 20 years has the reputation that goes hand in hand with that phrase. Nonetheless, the Ambulance Service in recent years has experienced the challenge of losing volunteers, particularly from its ALS ranks, as jobs change, people with ALS training want or need to be paid for those skills, and as employers can less afford to let employees respond to calls as was once a St. George tradition.

With fewer Basic EMTs (the minimum level required for St. George to respond to a call) and fewer ALS staff (those needed to provide certain sophisticated life-sustaining treatments) available locally, appropriate patient care is more subject to delay. Many calls can be handled by Basic EMTs alone and those may be less sensitive to delay. However, these may also cause slower “chute” times (time interval from dispatch to ambulance en route to call) and overall response time (time from dispatch to arrival of St. George EMS on the scene (see above for discussion of potential problem of calculating this with current definitions of “arrived at scene”).
Time critical emergencies often require ALS personnel and are more sensitive to delay. The audit identified at least one cardiac arrest call with a 25 minute delay for paramedic (ALS) arrival. By virtue of access routes and distance, the use of a neighboring service to respond to St. George will take much longer than the same level of responder from St. George. St. George responders have been good about summoning mutual aid when a higher level is suspected to be needed and not locally available, but the added minutes will still be there.

What are the response figures and how often is mutual aid required? This obviously varies with personnel availability, but can change as quickly as when the only Paramedic fairly constantly in town must take a job out of town for at least part of the week as has recently occurred. Or when some of a group of new EMTs leave town for school or other life transitions as may soon occur. The smart bet is that mutual aid calls will increase this summer and that chute and response times will be affected.

In 2009, the Ambulance Service’s average chute time was 10 minutes and response time was 16 minutes. Ashland Ambulance now pays on-call EMTs and paramedics to be within three minutes of the ambulance garage. Their chute time is 4 minutes and response time is 11 minutes. They also serve a 2,850 square mile response area, so travel time is going to be greater than that in St. George. Tag that 4 minute chute time onto St. George’s average 6 minute response travel time for a 10 minute total average response time and the 4 minute BLS/8 - 10 minute ALS standard is at hand. But at what cost?

An around the clock, paid EMT/Paramedic team could easily cost over $250,000 per year, and require a whole new personnel and accounting system in addition. The 2009 Association expense budget was $94,000, with revenue of $120,000 (includes large adjustments). At 180 calls per year, each call costs about $500. Add full-time response cost and the cost becomes $2,000 per call. With part-time on call response like neighboring services have established, the cost settles to just over $1,000 per call.

In 2008 and 2009, the Ambulance Director’s research of Knox Regional Communications Center records showed that 10% of calls resulted in mutual aid, either for ALS to respond (a third of those), or for both ALS and transport (2/3 of the total). The PCR audit indicated a 32% occurrence of ALS mutual aid in 2007 and a 17% occurrence in 2008 (in 2009 there were no documented cases of ALS mutual aid on the new PCR printouts…likely a documentation issue). Interviews and billing records from Thomaston and Rockland confirm a 10% to 15% mutual aid rate to St. George.

*Finding:* In St. George, the average response was 16 minutes in 2009. Mutual aid can be expected to be called between 10% and 30% of the time with commensurate delay in ALS care. With paid on-call staff, and staff restricted to distance from base like Ashland, it could have been 10 minutes. Ashland does not require ALS mutual aid except in unusual circumstances. The cost to accomplish this full-time would require the Service to seek Town subsidy and/or patient charges in addition to its current donations. With
pay incentives but no schedule or on-call restrictions, like NHAS, response times might marginally improve (they have longer response travel times too) but ALS mutual aid would still be at the higher end of the range experienced by St. George now).

**Recommendation:** The finding is somewhat instructive, but largely intuitive: if you pay a lot of money to guarantee that people will be available close by to respond, you will have faster response times and faster access to ALS. Does that equal better patient care? Maybe in some cases. How important is that to St. George, versus losing the tradition of the volunteer service, the lack of dependence on patient charges or the tax base? Can the Service justify doubling or quadrupling the cost of answering a call, and expect the patients or the tax base to cover it? This is a question that should be put to the residents of the town in an organized forum. They are the ones who bear the risk of not having the ALS in the case when it is really needed. They, too, are the ones who do or would foot the bill of whatever model is chosen. This is called “informed self-determination”. To have the Association answer these questions on behalf of the Town should only happen if the residents show no interest in participating. The primary question should be: what are the triggers for changing to another type of coverage? Is it no longer meeting the State’s 20 minute annual average response time (MEMS Rules Chapter 3, section 8)? Is it a 30%, 50%, or 70% of the time reliance on ALS mutual aid? Options should be developed and presented as clear choices at a forum for discussion and election.

**Finding:** While services with relatively small call volumes have managed to find local support to provide full-time ALS coverage, they have tended to be more isolated (30 – 60 minutes travel time depending on location of call) from neighboring services and seen as lone sources of definitive emergency care (and sometimes informal primary care). Ashland and Rangeley are examples. St. George has reasonably close neighboring services in Thomaston and South Thomaston. Both have per diem staff 6 AM to 6 PM. Thomaston averages 500 calls a year while South Thomaston had over 150 calls last year. Together with St. George, they would have a call base of 800 or more calls per year. At over two calls per day, a critical mass of affordability and operational and financial practicality is reached. Logical mid-points exist for basing responders (Rtes. 73/131 or 131/Westbrook Street intersection areas. Examples of different cooperative models abound, from sharing an ALS response service or staffed vehicle, but maintaining separate local services, to sharing centralized per diem staff basing costs, to total merger. There are political, historical, and recent school regionalization biases evident among interviewees which argue against exploring any regional, cooperative agreements.

**Recommendation:** Regardless of the outcome of a town forum or other shorter-term operating decisions, regional cooperative efforts are virtually inevitable given today’s economy, EMS staff supply circumstances, and increased demand for ALS services. Smaller efforts at 150 – 500 calls each in the three most local towns are economically and operationally difficult to justify. An expensive service with staff sitting around with nothing to do most of the day is a negative from the public’s view as well as from the EMS professional’s. Combining a professional EMS position with other work, particularly menial work, rarely succeeds. The Executive Committee should charge the
EMS Chief with exploring new cooperative relationships with Thomaston, South Thomaston and perhaps other services to achieve a financially and operationally more favorable critical mass of call volume and set of patient services. The result should be brought as an option to the Town’s residents in a future informed self-determination process.

Establishing a coverage schedule has been difficult with clear divisions over its pros and cons. Some feel it takes away from the volunteer, “respond to the whistle” tradition, while others feel that it establishes boundaries between what is committed to the Service and what can safely be reserved for family and work responsibilities and enjoyment. Clearly, a full schedule provides some assurance of the reliability of response and an opportunity to really know what your minimum resources may be at any given time in the NIMS resource sense.

But, the schedule has to work. The current effort is due to be voted up or down after a year’s trial.

**Finding:** The scheduling effort should continue to be developed. The officers should work with the volunteer who has lent his time, skill, and perseverance to this effort to develop this into a workable system. Suggestions that smaller scheduling blocks of time may work better for volunteers, or other tweaks as members may suggest, should be given a chance. The scheduling effort has suffered from internal conflict issues that have nothing to do with the schedule and are addressed below. It has not been given an adequate trial. Other services without schedules, even those with incentive pay, have difficulties in improving response. Scheduling by “times not available” is not generally a successful approach. It is better to have people commit to times they are available with a responsibility to first seek a replacement, and if not possible to notify the crew that the scheduled slot is no longer covered.

**Recommendation:** Continue the schedule experiment at least until the end of the year and until the Executive Committee is given its operational authority. At that time the schedule system should be adopted, revised and adopted or rejected by the Executive Committee. When adopted, members will be required to use the scheduling system as detailed by the Executive Committee. Until then, members should be allowed to use the schedule or not as they wish to organize their response availability. Those who are on the schedule shall be the default crew on a call for any given scheduled period and others who show up may be utilized or not at the scheduled crew’s determination.

A volunteer service has special recruitment and retention needs. One resource that may be of value in this regard is a recruitment and retention toolkit developed by the Virginia Office of EMS, a longstanding leader in the nation in these efforts for its state’s providers. Go to [http://www.vdh.state.va.us/OEMS/Recruitment_Retention/index.htm](http://www.vdh.state.va.us/OEMS/Recruitment_Retention/index.htm) for more information.
The SGVFAA provides personal protective clothing, t-shirts and other informal uniform elements for Ambulance members, and has an end of year holiday social event for all members.

**Finding:** Volunteer services promote volunteer EMS professionalism in many ways. Some basics include recognition dinners and awards on at least an annual basis for such things as hours donated, calls attended, extraordinary care, and acts of professionalism and/or caring. They also equip volunteers to look professional on the scene and in public. Volunteers can have a service-established regulation uniform (as simple as cargo/utility/BDU pants, a logo emblazoned polo shirt or button shirt, and safety boots) when they have the luxury of responding from someplace they can wear these to respond from (e.g. home/around town) when on scheduled duty. They can be given logo emblazoned jumpsuits to put on when not. The t-shirt and jeans approach may be the only solution in some cases, but uniforms inspire confidence in responders and patients (and perhaps in those who might aspire to join the service).

**Recommendation:** The Citizens Advisory Group, and its representative on the Executive Committee, as recommended above, should work with the EMS Chief and Executive Committee to establish and carry out recognition activities on a regular basis. The EMS Chief should work with the Executive Committee to review and revise the uniform policy in consideration of the finding. Money sought through a modest Town subsidy recommended below for establishment of a command structure should provide funds for professional uniforms and, as needed, personal protective gear.

St. George has taken advantage of the federal AmeriCorps initiative to fill a “volunteer” (stipended through a combination of local and federal funds) firefighter/EMT position. This person serves as a responder for both SGVFAA services, and fills his spare time with maintenance, inventorying, and administrative tasks to the benefit of both.

**Finding:** St. George demonstrates initiative and creativity in establishing and securing funding for the AmeriCorps position. It is of value both in maintaining response readiness and in improving response capability.

**Recommendation:** St. George should continue to apply for at least one position as long as this program remains available, and use the position as it is currently doing.

**Documentation**
The changeover to a new State EMS data system (Maine EMS Run Reporting or MEMSRR) has produced a learning curve and data glitches statewide (hence some of the data problems mentioned above and contained in the reports for the two comparison services and St. George.

In interviews, there were related problems involving the location of the mobile computer unit in the ambulance (being in the front seat) and the perception that completing electronic patient care/run records (“PCRs” - - versus the previous handwritten PCR)
was adding one to two hours to the previous total time required for a call of two hours. Clearly, this is a concern in a volunteer service where people need to get back to their other lives as quickly after calls as possible. It can impact the ability to recruit and retain volunteers.

On the first issue, location of the mobile computer depends on the functions anticipated for the unit. These should be discussed with members and decided upon by the EMS Chief and officers. If the unit is to be used solely for PCR completion, it should be able to be moved between compartments so that some completion may be done and information obtained on repeat patients en route to the scene as is enabled by MEMSRR. When moved back, it can be used to enter information as time allows with patient care. If the unit is used for GPS route finding or other information as data systems mature, it is important that the driver not be allowed access while the vehicle is in motion. Recent reports have documented an increase in police and ambulance vehicle incidents attributed to driver use of onboard computers while moving.

On the second issue, Maine EMS has documented that St. George’s average connection time to complete run records is just over 30 minutes. Interviews and sampling done during the PCR audit document, respectively, great variation from member to member in the time required to complete electronic reports and time spent at the hospital after patient delivery. Total “Time Out to Time In” data provided by the Service from its “card system” for recording calls shows an annual average total call time (for completed transport calls to Pen Bay only) of 131 minutes in 2008 (before the PCR changeover), 146 minutes in 2009 (after the changeover), and 173 minutes in the first quarter of 2010. The evaluator PCR audit found from the sample audited in 2009, that there was an average of 53 minutes spent at the hospital (similar figures were not recorded on the 2007 and 2008 PCRs audited.

Related to the PCR completion time issue is the ability of members to adequately document their calls. When performing the PCR audit of St. George run records for 2007 to 2009, the “EMS story-telling gold measure” against which each record was judged was: “could a provider at or above the level of the person completing the record understand what was encountered, what was assessed, what action was taken or treatment was given and with what result, and whether the actions taken and treatment given were consistent with assessment and within Maine EMS protocol and other standards of care?”

Audits of the 2007 and 2008 handwritten PCRs found generally well-organized information and narratives, usually using the SOAP or another traditional medical reporting format, especially by EMT-Ps and EMT-Is. Records from EMT-Basics often told the story in a rudimentary fashion, leaving out explanations of why certain things were or weren’t done. While generally done in a “we saw or were told that and we did this as a result” fashion, rarely were organized SOAP or other formats used. There were rarely good explanations of transitions to handing over care to a mutual aid medic.
In 2009, the situation worsened as everyone seemed to struggle with the MEMSRR format. The EMS story-telling gold measure, described immediately above, was frequently not achieved. Narratives were often incomplete or, using automatic completion features of the software, were redundant and wordy. Cardiac monitoring is many times indicated without indicating what was seen on the monitor. Effects of treatment are rarely recorded. Physician orders are generally not described when they should have been a part of care. The good news is that this notably improved as the year went on.

**Finding:**
Some, but by no means all, St. George members have taken MEMSRR training. This compromised the ability of previously good documenters to tell the story needed. It virtually muted previously poor documenters in a number of cases. While it clearly has added some time to the process and time spent in the ED, an extra 15 minutes demonstrated in 2009 during the biggest learning curve, or even an extra 40 minutes in the first quarter of 2010, is not the extra one to two hours so many feel it is. Nonetheless, it should not be increasing, and a one hour average spent in the ED is probably unnecessary, if one person spends the 30 minutes on the PCR that Maine EMS has for connection time and the rest of the crew gets the ambulance ready.

**Recommendation:** All crew members responsible for completing PCRs should take a MEMSRR class sponsored by Maine EMS. A policy should be established that a uniform PCR format (SOAP, etc.) be chosen by each provider and that a class be held on the formats elected.

**General Operations**
As has been described already, the SGVFAA Ambulance Service has the reputation of a well-oiled EMS response team that has been built over the years. Not that creating or maintaining this was ever simple, but twenty to twenty five years ago, there was energy among a relatively young core group of EMT and Paramedics. Employers were more likely to allow them to respond to calls (Harbor Builders alone fielded 6 to 9 at any given time), and the economy wasn’t quite as grim as it is today. There was social knitting and satisfaction to be taken from that aspect of the Association in addition to a job well done. ―Cooperation and communication were the key all along‖, said long-time Association member Bill Reinhardt in his interview. Apparently, the spirit and energy to serve patients, a general camaraderie, and informal interaction and understandings were enough oil to keep the response machine effective.

Today, the machine squeaks and groans. Interviews reveal a recent history of ineffective communication from the Association to the Executive Committee, to the chiefs and back around. There are widespread complaints about too many chefs in the figurative ambulance service kitchen vying for control, and uncertainty about who is in charge. It is evident that no longer can natural “cooperation and communication” informally enable a smooth operation. It takes leadership and work, and the time and skill to meet all of the
demands of running a small but complex business. At least one Ambulance Director estimated administrative time spent at 1,000 hours in a year (nearly a 50% full time job). That included developing policies and procedures that were legally or operationally important, doing the many tasks to keep the vehicles stocked and ready, representing the service in venues from which the service would benefit, and learning about being an EMS leader and manager. That is the spirit needed to lead St. George today. But it will take more resources than are being invested today.

These resources could go to pay a full-time EMS Chief or Fire/EMS Chief, or an hourly EMS Chief as Ashland has. Or the same resources could be spread among a number of officers through stipends, addressing multiple functions, incenting members to take the responsibilities, and creating not only an advancement ladder to produce a reliable pool for Chiefs with leadership experience, but a command structure with redundancy of leadership for critical events when the EMS Chief may be unavailable.

**Finding:** Interviews indicate that a broader command structure through a corps of part-time stipended officers would benefit the EMS Service as much as it does the Fire Service in St. George. While multiple chiefs in a fire department may relate more to having a chief available to command every incident, having multiple officers in an EMS service reflects the complexity of the combined business of emergency patient care and public safety response, and a greater call volume. The St. George EMS Service needs leadership and management help. It also needs an advancement ladder and an officer corps to help communicate the leadership’s messages continually and widely. One Ambulance Director working odd hours in an empty ambulance garage is limited in his or her ability to effectively communicate to the troops. Multiple officers coordinated and regularly communicated with by the EMS Chief and communicating to other members cannot but help overall communications.

**Recommendation:** Within budget, initiate a command structure that continues down from the Executive Committee/EMS Chief governance structure described above and involves, at a minimum, a truck captain and lieutenant (or equivalents) whose responsibilities have been previously recommended; a QI/Training captain and lieutenant (or equivalent) whose responsibilities have been described above; and a Chief Medical Officer who is a staff deputy chief or equivalent (not in the command structure line – you obey him medically, but you do not salute him!). All officers, except the Chief Medical Officer (unless he/she opts to), should be NIMS, ICS and MCI trained to take charge of major EMS scenes and the medical sector of ICS events.

**Recommendation:** The stipend for the EMS chief should be at least commensurate with that of the Fire Chief. Other part-time stipends should be appropriately stepped within the budget (the magnitude is expected to be the same as the fire budget for officers: approximately $4,000 for the chief, and $2,000 to $3,000 for the others). If the budget does not support this approximately $15,000 in costs based on the donation base, budget subsidization from the Town for at least this purpose should be sought. The ability to put this command structure in place should not be compromised by fund-raising success or
the cycles in revenue health apparent in budgets over the past few years. It is easier to fund-raise for vehicles, equipment, uniforms, and supplies for volunteers to provide service than it is for operational stipends of this sort.

Telecommunications
The Ambulance Service and Fire Department have had issues with dead zones in the area and have worked with Knox Regional Communications Center (KRCC) to resolve these. St. George leaders have been active in the KRCC advisory board and in seeking relief for their issues. The KRCC has been ahead of the curve in addressing narrow-banding of the frequencies employed by the Ambulance Service and seems to have this issue in hand with ambulance services and the hospital alike. KRCC is a Maine EMS approved Emergency Medical Dispatch center that operates a QA program. There have been some problems with effective EMD being performed according to EMS leaders around the County, however, this should improve with time.

Internal Communications, Records and Safety
In a volunteer setting such as St. George EMS, the opportunities for communication come at monthly training sessions, QI/QA sessions, and Association meetings. Not everyone can attend all meetings, and there is not always an EMS Chief in town to consult when a member needs to (can improve with the broader command structure recommended). In the increasingly complex business of EMS, it is vital that all responders have the same set of operational expectations when they answer a call. Some of this comes from training and experience, but some must come from written policies and procedures.

In his interview, Tom Judge offered the following: “I work in a hospital system and we have lots of policies and procedures but it is not always clear how they affect the day to day. My take—keep it simple. There should be just 4 policies — not always graceful but you will get the right result:

#1 Stolen right from the US Army—every day when you come to work be all you can be.
#2 Treat every patient like they were your mother.
#3 Stolen from Spike Lee—always Do the Right Thing.
#4 When all else fails, feel free to think, it is always an option.”

Finding: With that wisdom in mind to keep from going overboard, a lack of well-communicated policies and procedures was the subject of criticism in many interviews. However, the Service and Association also provided some policies developed in the past two years or so, and some which are currently being considered. There are some policies that a service must have such as those required by Maine EMS, as previously discussed, or OSHA, and some that will make operational response more effective. New policies and procedures should be suggested by the QI/QA process and the need for change in how the response and patient care system works. Draft procedures should be circulated among members and at Association meetings for comment. Where a policy requires knowledge on the part of Members to act, such as in decontamination and the use of the decon facility in the fire station (an area of apparent weakness per interviews) these must
be included in documented training not only as required but as needed to be effective. Training records exist in personnel files, “Super Sunday” annual training lists and perhaps elsewhere, but not reliably or consistently.

**Recommendation:** The EMS Chief should review Maine EMS, OSHA, CLIA, and other authorities with enforcement power over the Service (Maine EMS and the Maine Ambulance Association should be useful in this regard) and review, renew or revise policies as required. New policies and position descriptions should be developed per the finding. Once approved by the EMS Chief in consultation with the Executive Committee, members should sign acknowledgements of these and file them in personnel files which exist. Adjust training accordingly. QI/Training officer staff should reliably file all training records in personnel files. Non-operational policies, procedures and position statements should be developed and approved by the Executive Committee, with input from the members.

**Budgeting and Finance**
Operating income and expense statements for the years 2003 through 2009 were reviewed. It is reiterated that professional auditing review is not a part of this evaluation, nor are there any attempts to make financial projections or patient billing potential estimates. The reporting format presented in the appendices is clear and presents no inconsistencies. For the recommendations in this report that involve additional expense, decisions about seeking Town subsidy or using reserves must be made. The reports contained in the appendices reflect operating funds and give a good picture of operating health and end of year balance history. For the decisions mentioned, statements reflecting reserve funds should also be considered.

The statements reflect an annual fund-raising capacity in the $60,000 to $85,000 range (improving in recent years). Expenses went up after 2004 with the purchase and insuring of the 2004 ambulance and the establishment of ambulance and training building funds. Insurance rates went down when an ambulance was transferred to Town ownership. The budget seems to straddle the profit/loss fence pretty closely in 2009 with fundraising down and expenses continuing a pattern of increase. In earlier years there was more of a cushion.

**Community Relations and Services**
The service participates well in community service provision, but also seems to recognize the limitations of the capacity of its response volunteers to participate in these. It has created a Citizens Advisory Group/Committee which employs non-response volunteers in the community to assist with fund-raising, community-relations and operational support activities. Many interviewed stated that the true volunteer, non-charging, community-oriented nature of the service is not understood in the Town (and that many think it is Town funded and run). Community relations efforts as suggested in pictures below have benefitted from the Citizens Group.
THE ST. GEORGE AMBULANCE SERVICE

WE NEED YOU

BEFORE

YOU NEED US

VOLUNTEER NOW

SEE CHRIS FERGUSON OR TIM POLKY

ABOVE & BEYOND

Your Volunteer Ambulance Service does more than just answer emergency calls

Talk to school children and others about medical emergencies and 911 calls

Help prepare fundraising diaries

Training, training, training

Meds by doing community events like the Bermuda bike ride

Gather donations for education fundraising diaries and calls

Contact our kids ambassadors and participate in parades

Donate items, wear the dollars. Feed the St. George Volunteer Ambulance Service. Remember: WE NEED YOU BEFORE YOU NEED US.
**Finding:** This Citizens Advisory Group type of activity has been suggested in many volunteer EMS organizations but rarely gets off the ground. While there have been occasional toes stepped on where “old guard”/traditional and new volunteers in a certain effort mix, most feel that it has been value added and has the potential to be even more effective. Dan Fales and others who have been cited as making this successful are to be commended.

**Recommendation:** The Executive Committee should welcome these efforts and encourage the Citizens Advisory Group (CAG) to formalize as much as possible so that it will continue as leaders come and go. As previously suggested, it should elect a representative to serve on the Executive Committee. It should be encouraged to meet as a group and suggest new ways that it might assist, in addition to helping in ways already established. Again, it should become the driver of a new EMS volunteer (and CAG volunteer) annual recognition initiative.

An initiative to maintain an updated website and to begin an SGVFAA newsletter for mailing to residents and in the annual appeal letter is commended.

The Project Working Group for the evaluation asked for samples of patient satisfaction surveys. These are provided in the appendices.

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The following is a “strengths, weaknesses, opportunities, and threats” (“SWOT”) analysis with recommendations. It is based on the results of a SWOT exercise accomplished during the evaluation which employed the SGVFAA designated Project Working Group (Candy Davis, Keith Miller, Steve Jarrett, Chris Milton-Hall, and Tara Elwell).

The purpose of the exercise was to confirm the input from the interviews conducted and the data analyzed, but in a group setting (two members who could not attend were solicited after the session). Findings and recommendation already made are not repeated. Issues previously discussed which did not include a Finding/Recommendation, but which are confirmed here, generated a Finding and Recommendation below.

The group first brainstormed strengths and weaknesses of the Association and Service. These are not listed in a priority order. They then identified and organized threats to and opportunities which exist regarding the Service and Association. The contractor had nothing to add to the lists.

**Strengths** (Not in priority order.)
- Group of young EMTs
- Most members like each other and work well together
- Top notch equipment
• Good Community support
• Good training made available in house and at conferences/courses out of town
• Good seasoned veterans willing to help new crew members
• Core group of members willing to put in a lot of time
• Core group has same caring spirit; remember why they joined in first place
• Scheduling system
• 60 years of on-going service to Town
• Pride in being volunteer/non-tax-based/non-charging service
• Good support from members’ families to allow them to serve
• Citizen Support/Advisory Group takes some pressure off responders to do non-response functions
• Town government in-kind support helps
• Good mutual aid relationships
• Historically EMS & Fire Dept. work extremely well together – like well oiled machine. Each service watches out for the other services personnel, safety & training.
• Professionalism-The service has always prided itself in the level of professionalism it provides as a volunteer service and tries to instill this pride & respect with new recruits.
• Ability to accept responsibility.

Weaknesses (Not in priority order.)
• Major interpersonal issues among certain members interferes with recruitment and retention of volunteers
• Methods of communicating to staff.
• Association and ambulance command structures are vague. By-laws are vague. Need more structure and willingness of all to work within those structures.
• Resistance of a few to the scheduling system creates confusion.
• Not enough ALS coverage; not in timely fashion when mutual aid.
• Low membership.
• Same small group doing fund-raising and other non-response support.
• Citizens Support/Advisory Group does what is asked but is not creative in coming up with new ways to fund-raise or provide support. Sometimes current members are not receptive to new ideas.
• Many EMTs answer few or no calls. Some pick and choose based on who else is on call and what the call is.
• Young EMTs are leaving because of being hassled by older members or being burned out.
• We train new members who then leave for paying EMS jobs.
• Geography of response area creates long response and total call times.
• Total time on calls is too long for volunteers.
• Don’t do fund-raising appeal more than once and don’t follow-up on that appeal. 1600 town residents don’t donate at all.
• Arrogance amongst a few causes disrespect & lack of confidence for others in authority.

**Opportunities (and Possibilities)** (The first one received more than all the rest combined. The remaining 5 italicized priorities received small support, and Billing (explore) just one vote. Non-italicized were suggested but got no votes.)

• Improve the Association decision-making/operating structure and the ambulance service command structure. Not everyone “owns” the ambulance or should have an equal say in operating it on a day to day or month to month basis (too cumbersome and disorganized). Officers should be given responsibility for decision-making and the Executive committee should be elected to make decisions from week to week and month to month (seeking member input as time allows).
• Improve recruiting and retention.
• Stay non-charging.
• Create incentives for EMTs to go to Intermediate and then Paramedic.
• Inform and involve public more in what is going on.
• Billing (explore).
• Merge with other services (regionalize in some way).
• Transfer service to town and make tax-supported (minimal impact on tax base).
• Pay people (explore).
• Stay non-billing.
• Hire ALS staff.

**Threats.** (The first four – italicized - received all the votes, with the first receiving twice as many as all the rest. Non-italicized were suggested but got no votes.)

• Interpersonal issues among members, and their cliques, and needling and bickering by them together and individually against other members jeopardizes the Association and service and continue to cause morale issues.
• Lack of commitment among members.
• Lack of discipline. No consequences for disruptive behavior. Can’t effectively fire members. Lack of association effective decision-making structure (executive committee empowerment) or ambulance command structure with authority to assist with these and more efficient effective operational decision-making.
- Lack of leadership opportunities and lack of ladder of increasing responsibility to grow leaders (e.g. Lieutenants and Captains) in ambulance service. EMS officers interfered with and undermined by fire officers.
- Lack of donations.
- General economy is down.
- Mutual aid use may become excessive; more residents getting billed; response delays.
- Lack of membership.

Finding: There is a desire expressed in interviews and in this process to remain non-charging. It has been recommended that Town subsidy be sought to support some incremental command structure and volunteer recruitment expenses. The Association may find that any new Town subsidy for the Ambulance, even as modest and important as this, is a trigger for citizen consultation in the forum previously suggested. It has also been recommended above that “triggers” be established for considering pay and other incentives or policies for staffing, and that these be established in the informed self-determination setting. It should be recognized that the more mutual aid transports are conducted, the more Town residents are being billed for services by neighboring ambulance services.

Recommendation: Similar Once triggers have been activated indicating a need for operational staffing pay and significantly increased expenses, similar triggers should be established to indicate where revenue will be sought (e.g. new fundraising, Town subsidy, or patient billing).

Finding: Association members may be terminated following a cumbersome and unlikely by-laws-created process. Vagueness surrounds the issue of terminating active EMS members who may or may not be a member of the Association.

Recommendation: Utilizing management support resources recommended previously (e.g. membership in NEMSMA), the EMS Chief should establish and employ a disciplinary process that effectively warns members of conduct unbecoming of an EMS professional and/or other issues, and provides clear paths to rehabilitation or termination. The Association should also have such a policy for members who remain disciplinary problems though perhaps terminated by one service or the other.

Finding: Interpersonal relations appeared to be among the most important areas needing resolution. This involves a conflict among staff alluded to elsewhere herein. This is believed to be able to be corrected with the implementation of other recommendations concerning governance.

Recommendation: Implement changes in governance reflected elsewhere in the report.