DEPARTMENT OF PUBLIC SAFETY
MAINE EMS
STATE OF MAINE

MAINE EMS
SERVICE LICENSE APPLICATION

For what license are you applying?

- ☐ 1. New Service License
- ☒ 2. Upgrade in License Level
- ☐ 3. Downgrade in License Level
- ☐ 4. Change in Permit Level
- ☐ 5. Change in Primary Service Area
- ☐ 6. Change in Service Name
- ☐ 7. Change in Base Location
- ☐ 8. Paramedic Interfacility Transport (PIFT) Endorsement

Section I - Service Information

A. Service Name: ROCKPORT FIRE DEPT. Service #: 1074

Mailing Address: P.O. BOX 142 Shipping Address: 85 MAIN ST.

City: ROCKPORT State: ME Zip: 04856 City: ROCKPORT State: ME Zip: 04856

B. Business Telephone #: 207-236-4437 Fax #: 207-230-0112

C. Federal Tax ID# (EIN): 46-5532615 E-Mail Address: JPEASLEY@ROCKPORTMAINE.GOV

D. Physical address of bases used by this service

1. Street: 85 MAIN STREET City: ROCKPORT State: ME Zip: 04856

   Telephone #: 207-236-4437 Fax #: 207-230-0112

   Base Primary Contact: JASON PEASLEY - FIRE CHIEF

2. Street: 624 WEST STREET City: ROCKPORT State: ME Zip: 04856

   Telephone #: NOT YET AVAILABLE Fax #: N/A

   Base Primary Contact: _____

3. Street: _____ City: _____ State: _____ Zip: _____

   Telephone #: _____ Fax #: _____

   Base Primary Contact: _____

4. Street: _____ City: _____ State: _____ Zip: _____

   Telephone #: _____ Fax #: _____

   Base Primary Contact: _____

Section II – Service Administration

List the names and telephone numbers of the service administration. (Note: this list will supersede all previous lists).

A. DIRECTOR: JASON PEASLEY *Maine EMS License #: N/A (* If no EMS License, mark N/A)

E- Mail address: JPEASLEY@ROCKPORTMAINE.GOV *Date of Birth: 3/15/1974 (* Required if no EMS License)

Telephone #: Home: 207-763-4499 Work: 207-236-4437 Cell: 207-446-8620

B. ASSISTANT DIRECTOR: COREY BONNEVIE *Maine EMS License #: 22210 (* If no EMS License, mark N/A)

E- Mail address: EMSSUPERVISOR@ROCKPORTMAINE.GOV *Date of Birth: 9/24/1983 (* Required if no EMS License)

Telephone #: Home: _____ Work: _____ Cell: _____

C. ADDITIONAL REPRESENTATIVE: JOSEPH C. MOORE *Maine EMS License #: 17095 (* If no EMS License, mark N/A)

E- Mail address: JOE.MOORE@ROCKPORTMAINE.GOV *Date of Birth: 8/19/1977 (* Required if no EMS License)

Telephone #: Home: _____ Work: _____ Cell: 207-542-6892

D. SERVICE MEDICAL DIRECTOR: MARK MCALLISTER, MD *Medical License #: 18562 (* Required)

E- Mail address: MARKMCALLISTERMD@GMAIL.COM *Date of Birth: 2/24/1980 (* Required if no EMS License)

Telephone #: Home: _____ Work: 207-301-8333 Cell: 207-542-5894

E. INFECTION CONTROL OFFICER: JOSEPH C. MOORE *Maine EMS License #: 17095 (* If no EMS License, mark N/A)

E- Mail address: JOE.MOORE@ROCKPORTMAINE.GOV *Date of Birth: 08/19/1977 (* Required if no EMS License)

Telephone #: Home: _____ Work: _____ Cell: 207-542-6892

F. PRIMARY QA/QI CONTACT: JOSEPH C. MOORE *Maine EMS License #: 17095 (* If no EMS License, mark N/A)

E- Mail address: JOE.MOORE@ROCKPORTMAINE.GOV *Date of Birth: 08/19/1977 (* Required if no EMS License)

Telephone #: Home: _____ Work: _____ Cell: 207-542-6892

Section III - Service Type

A. Organizational Type: a. ____ Community, Non-Profit b. X Fire Department c. ____ Governmental, Non-Fire

d. ____ Hospital e. ____ Private, Non Hospital f. ____ Tribal

Note: If you checked boxes a or e above, you must attach 4 character references in accordance with Chapter 3 §5.1.C.4.

B. For what type of service license are you applying?

X 9-1-1 Response (Scene) with Transport Capability _____ 9-1-1 Response (Scene) without Transport Capability

_____ Scene Response Air Ambulance _____ Transfer Air Ambulance Service _____ Restricted Response Air Ambulance Service (RRAAS)

Section IV - License Level

Please indicate the license level at which the service can provide at least one EMS provider, licensed at the level of the service, on all emergency medical calls. This is the license level you may advertise.
(Note: Transporting Ambulance Services may not license at the first responder level).

__ Emergency Medical Responder X Emergency Medical Technician _____ Advanced EMT _____ Paramedic

Note: If applying for licensure at the Advanced EMT or Paramedic level, a copy of the service's agreement with a hospital pharmacy (or other Maine EMS approved pharmacy) must be attached to this application.

Section V - Service Permit Level

Please indicate the level of care to which the service requests authorization to provide on a part time basis. This is the permit level of the service, and may not be advertised to the public.

_____ Emergency Medical Technician _____ Advanced EMT X Paramedic

Note: If applying for permit at the Advanced EMT, or Paramedic level, a copy of the service's agreement with a hospital pharmacy for the dispensation of drugs must be attached to this application.

Section VI – PIFT Endorsement

PIFT Quality Assurance/Quality Improvement Plan- ***Please include a written copy of the plan your service will use to review 100% of PIFT transports.***

Service Medical Director- Please list the name, address, and phone number of the Maine licensed physician who will be serving as the Service Medical Director for all PIFT transports.

Name: _____ **Business Telephone #:** _____

Mailing Address: _____

City: _____ **State:** _____ **Zip:** _____

As the service medical director for _____**, I agree to provide medical oversight of paramedic interfacility transports under the Maine EMS PIFT Program, including operational support, education, and 100% QA/QI of all PIFT transport reports and QA forms as required by Maine EMS and the MDPB.**

Signature: _____ **Date:** _____

Section VII - Service Area

Primary Response Area - List, by city or town, the service's Primary Response Area. A Primary Response Area is defined as the area(s) to which a service is made routinely available when called by the public to respond to medical emergencies.

ROCKPORT

Section VIII - Quality Assurance/Quality Improvement Committee

List the position (e.g. Service Director, Paramedic, EMT), the members of your service's Quality Assurance/Quality Improvement Committee, and attach a copy of your services quality improvement program

JOSEPH C. MOORE — DR. MARK MCALLISTER — CHIEF JASON PEASLEY

COREY BONNEVIE

Section IX - Communications

A. Describe the method for public access to the service; the name of the dispatch center; explanation of the dispatch method and procedures; type and quantity of communications equipment to be utilized; and a list of radio frequencies utilized by the service (use additional sheets as necessary):

KNOX COUNTY REGIONAL COMMUNICATION CENTER IS AT 301 PARK ST., ROCKLAND. THEY ARE THE LOCAL PSAP WHO RECEIVES AND DISPATCHES ALL OF OUR EMERGENCY COMMUNICATIONS AND ARE FULLY EQUIPPED.

KRCC RECEIVE: 152.2025 TRANSMIT: 158.6675 ROCKPORT: 154.19

B. Please list the following agencies and their telephone numbers:

Public Safety Answering Point (9-1-1 Center): KNOX RCC PSAP Business Tel #: 207-594-5656 (Other than 911)

Dispatch Agency: SAME Dispatch Business Tel #: SAME

Section X - Vehicle Information

A. List, below, the vehicle(s) for which the service requests ambulance vehicle licensure (attach extra sheets as necessary):

Maine EMS #	VIN# (Full 16 Character)	DMV Registration #	State	Chassis Manufacturer	Ambulance Manufacturer	Chassis Year	Vehicle Type
1104	1GDE4V1246F401558			GMC	HORTON	8/05	I

B. List, below, the Emergency Medical Services Vehicle(s) (EMSV) for which the service has received Maine EMS authorization. Do not list vehicles in this section that are licensed as ambulances or fire service vehicles.

Maine EMS #	VIN# (Full 16 Character)	DMV Registration #	State	Vehicle Manufacturer	Vehicle Model	Vehicle Year	Vehicle Type

Section XI - Personnel

Please attach a current list of Maine EMS licensed personnel for your service.
(If the application is for a request to permit only, list only those personnel who are licensed at the proposed permit level.)

Section XII - Non Transporting Services Endorsement

A. Transporting Service Endorsement for Non Transporting Services

I certify that the below named ambulance service has a letter of understanding or other written agreement in effect with the applicant which provides for the simultaneous dispatch, and transport of patients, as required in chapter 3 §5.1.C.5 of the Maine EMS Rules.

Name of Transporting Service: _____ Service #: _____

Signature of Authorized Representative: _____ Date: _____

Print Name of Authorized Representative: _____

Section XIII - Service Representative Endorsement

I hereby certify: that the foregoing statements are correct and true to the best of my knowledge; that the service is eligible for licensure/authorization in accordance with the Maine EMS Rules and EMS Law (32 M.R.S.A. § § 81 *et seq*); that the service possesses the required equipment as set forth in the Maine EMS Rules; and, that the personnel providing medical care on behalf of the service possess current and valid Maine EMS licenses. The service requesting licensure understands that the Maine EMS systems Quality Assurance /Quality Improvement (QA/QI) process is an integral part of being a licensed Maine EMS service and agrees to participate in the Maine EMS QA/QI system in accordance with criteria approved and published by the Board, and further agrees that QA/QI information pertaining to the service may be shared amongst recognized participants within the Maine EMS QA/QI system. I request that the Maine EMS Board approve any changes indicated regarding the Service's Quality Assurance/Quality Improvement Committee (in accordance with 32 M.R.S.A. § §92-A *et seq)*. I understand that making a false statement that I do not believe to be true on this application or knowingly creating or attempting to create a false impression by omitting information necessary to prevent this application from being misleading constitutes a criminal offense, and may be prosecuted as, among other offenses, unsworn falsification pursuant to 17-A M.R.S.A. § 453 (Class D) and may also result in disciplinary action against the service's license by Maine EMS.

Print Name: JASON PEMSLEY Signature: _____ Date: 10/9/24

FEE SCHEDULE

Service Fee - $100.00 per Licensed per year
Transporting Ambulance - $60.00 per Ambulance
EMS Vehicle Fee - $60.00 per vehicle*.
*Fire Based Services, there is no fee to license non-transporting EMS vehicles.

Payment Authorization – Applicants may charge the cost of the service license and/or vehicles to their credit card.

I authorize the Department of Public Safety, Bureau of Maine Emergency Medical Services to charge my:

VISA MASTERCARD DISCOVER (circle one) the following amount: $_____

Card Number:_____Expiration Date ____/_____mm/yyyyy
Name of Card Holder_____
Billing Address of Card holder_____

SIGNATURE_____DATE_____

Applicants may also pay by purchase order or check. **Make checks payable to:** ***Treasurer of State Maine***

Mail your signed application (photocopied, faxed or scanned signatures cannot be accepted) and fees to:

Maine EMS
152 State House Station
Augusta, Maine 04333.

Please call Maine EMS at 207-626-3860 if you have questions.

KNOX COUNTY FIRE SERVICE REVIEW
&
EMERGENCY MEDICAL SERVICE ASSESSMENT REPORT

Draft Report

July 2024

Neil D. Courtney

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Overview

The goal of this study is to gauge where the fire departments currently stand with regard to the 2015 "Further Collaboration" report, and what changes, if any, whether positive or negative, may have occurred. This study will attempt to identify where collaboration has occurred, which could be built upon to further the cooperative effort among the departments. Additionally, this project will acknowledge current and future challenges the departments are facing, and may offer recommendations to address those areas of concern.

This study will also delve into the operations of the various Emergency Medical Services (EMS) that provide service throughout Knox County. The assessment of the EMS services will essentially pursue the same objectives as the original 2015 study of the of the region's fire departments by capturing the essence of the individual ambulance services.

Aspects of the project:

- Comparative Analysis - What has changed in each individual fire department since the original study that was conducted in 2015.
- Comparative Analysis - What has changed collaboratively among the county's fire departments since the original study that was conducted in 2015.
- Poll the communities to determine what level of service they expect from their fire departments
- Assess the EMS services in Knox County. The purpose of this assessment is to establish fundamental understanding of the individual emergency medical services provided by each agency that operates within Knox County.
- Poll the communities to see what tolerance there is to have Emergency Medical Services delivered by fire departments.
- Poll the communities to see what the tolerance may be to add full-time positions to improve services.

Executive Summary

Over the course of the recent past, there has been much conversation about consolidating municipal services known by most as regionalization. It is theorized that merging individual fire and ambulance services may prove to be cost effective, boost efficiency and provide a more consistent delivery of those public safety services. It works elsewhere in certain areas throughout the United States, is there any reason we cannot incorporate that model within our modus operandi?

Regionalization is fairly elusive in New England where home rule reigns. Collectively, to an extent, we lack the political will to endorse a manner in which to deliver certain services to our constituents by blending our individual resources and assets with those of other entities. The fear of loss of identity and culture that is so inherent in each individual organization is cause to thwart any attempt to join two or more agencies into a singular, more expansive institution.

Perhaps the best we can do at this moment in time is to continue to focus on "coordinating" the separate and autonomous fire and EMS departments as opposed to merging them. Instead of consolidating the departments, perhaps a more palatable solution is to commit to advancing the cooperative nature that currently exists between the individual agencies. In essence, it looks as if the most practical strategy may be to stay on a path of continued and amplified collaboration.

It is evident that some of the communities in Knox County have addressed the scarcity of volunteer and on-call first responders by taking steps to stabilize response capacity, particularly in those municipalities that provide emergency ambulance service. Over the past 12-18 months, a number of new full time career and paid per diem positions have been created to ensure adequate and timely response by having qualified personnel on-duty at the fire and rescue stations. In all likelihood, the need to staff up emergency service positions will continue to be an issue requiring creative solutions and the infusion of additional financial resources.

FIRE SERVICES

THE FIRE DEPARTMENTS THAT SERVE KNOX COUNTY

The following synopses are highlights of what has transpired within each fire department since the original "Further Collaboration" study of 2015:

Appleton Fire Department

In 2021, the fire department took delivery of a new large capacity pumper tanker that is equipped with a 1,250 gallon per minute (gpm) pump and 3,000 gallon water tank. This procurement has modernized the department's fleet of apparatus so that the oldest vehicle is a 2001 model. The department also has an off-road Utility Task Vehicle (UTV).

The current fire chief was appointed to the position in 2022. Of the approximately 15 members of the department, eight to ten are active, with four qualified to use Self Contained Breathing Apparatus (SCBA). Appleton is working closely with the Union Fire Department in addressing shortfalls in emergency response adequacy.

Camden Fire Department

The Camden Fire Department is one organization that can be considered a combination department, which currently consists of four career personnel and a cadre of 15 on-call members. To some degree, the department has rearranged its fleet of apparatus as it sold its Engine #2, a 2004 pumper that carried 1,500 gallons of water, to the fire department in the neighboring town of Hope. This relinquishment reduced the Camden fleet by one major piece of fire fighting apparatus. Camden Engine #6, a 1982 conventional pumper, was replaced with a mini-pumper in 2022. In early 2023, the fire department began a "first responder" program. This arrangement has medically trained fire department personnel respond in conjunction with the contract ambulance service to medical emergencies throughout the community. The new Engine #6 is designed not only to suppress fires, but is also outfitted with medical equipment needed to render first aid to sick or injured patients who are then transported to the hospital by ambulance. Currently, the Camden Fire Department can only respond to medical emergencies when career personnel staff the fire station, which is from 6:00 AM to 6:00 PM seven days a week.

The Camden Fire Department has crafted an internal five-year strategic plan that outlines the department's future goals and objectives. This proposed venture is being deliberated by the town's administration. The fiscal 2025 warrant included funding for three additional full time fire department personnel that was approved by voters in June 2024.

Cushing Fire Department

In April 2022, the Cushing Fire Department took delivery of a new pumper/tanker that has a 1,500 gpm pump and a water tank with a capacity of 3,000 gallons. This procurement adds another large capacity tanker to the region's fleet designed for rural fire fighting where water sources are at a premium.

The department consists of 13 members and in 2023 responded to 57 calls for service. The fire chief also serves as the town's emergency management director.

Coastal Mountain Search & Rescue (CMSAR)

Although not a fire department, the CMSAR is a non-profit corporation that is made up of volunteers who are dedicated to wilderness rescue. The team works along side the region's fire, EMS and law enforcement agencies, and is trained to extract victims from remote backcountry locations as well as the ski lift at the Camden Snow Bowl. The team works out of Lincolnville's central fire station and utilizes a light duty rescue truck to transport its assortment of equipment.

Friendship Fire Department

The Friendship Fire Department added a new vehicle to its fleet of apparatus in 2021. The apparatus is outfitted with a 1,500 gpm pump, a 300 gallon water tank with a 30 gallon foam reservoir. Known as a mini pumper, this style vehicle is noted for being nimble and well suited to access tight areas such as camp roads and long narrow driveways.

The on-call department roster currently consists of ten members, most of whom are SCBA qualified.

Hope Fire Department

In 2020, the town of Hope purchased a conventional 2004, 1,500 gpm pumper that the town of Camden had deemed as excess equipment. The Hope Fire Department utilizes this apparatus more as a tanker in that it carries a payload of 1,500 gallons of water. This "new" addition replaced an older model.

The Hope Fire Department is currently staffed with approximately two-dozen members, and has experienced an uptick in the number of personnel responding to emergency incidents. The department is contemplating the implementation of a medical emergency first responder program.

Isle au Haut

No Report

Islesboro Fire Department

Perhaps the biggest news from the Islesboro Fire Department is that the town will be building a new two-bay station on the north end of the 14.29 square mile island. According to the fire chief, the town will relocate one pumper and one ambulance to this sub-station.

Lincolnville Fire Department

The most recent acquisition by the Lincolnville Fire Department is a 2021 pumper that is equipped with a 1,250 gpm pump and 1,000 gallon water tank. The truck was designed to carry the department's extrication tools and power equipment that were previously carried on an older light duty rescue truck, which has since been reassigned to the Coastal Mountain Search and Rescue Team. For the fiscal 2025 budget year, the department requested that personnel be compensated per hour when attending training sessions and responding to incidents, whereas personnel had been receiving a flat fee of $15 per incident.

The fire department transitioned from the Knox County Dispatch Center to the Waldo County Dispatch Center in March 2024. It was reported that two-way radio communications between Knox County and Lincolnville's portable and mobile radios were beset with dead zones.

The current fire chief was appointed to the position almost five years ago. The department has approximately 25 members with nearly one half of them certified as interior fire fighters.

The department is working towards relocating the fire station at Lincolnville Beach at some point in the future. A lot of land has been purchased, and the plan is to build when the department has amassed sufficient funds to carry the project forward.

In 2023, the department responded to 160 calls for service. It was noted in the annual town report that department is increasingly becoming involved with assisting in EMS calls. The department received a $5,000 matching grant from the Maine Forest Service.

Matinicus

No report

North Haven Fire Department

North Haven has a landmass of just under 12 square mile, and a year-round population of 417, the highest it has been since 1950. According to the 2008 Comprehensive Plan, the seasonal in-migration accounts for less than 1,000 additional people.

The town has recently opened its new $5 million combined public safety/public works building. For calendar year 2023, the department responded to 22 calls for service. According to the most recent annual town report, the department 's roster consists of nearly 30 personnel of which nine are qualified to enter a hazardous environment with SCBA. There are five junior members listed as well.

In 2022, the North Haven Fire Department purchased a used set of extrication tools from the town of Camden for $5,000. In 2021, a new chief was appointed as his predecessor retired after 38 years of service to the town.

There are 26 pressurized fire hydrants that are fed by a six-inch water main, and are located within the core of the island community. The fire department has access to multiple static water suction points, including seawater, to draft from for fire suppression purposes.

Owls Head Fire Department

The Owls Head Fire Department, which had been a "volunteer incorporated association" since organized in 1952, became a municipal department and identified as such with the passage of an ordinance in 2016. This maneuver puts the department under the direct authority of the Board of Selectmen. The town appointed a new fire chief in 2023 after the previous chief announced his retirement. The new chief has been a long-time member of the department. In 2021, the town procured a new large capacity pumper/tanker that replaced a 1990 model that was removed from service in 2019. The new apparatus is outfitted with a 1,250 gpm pump and a 3,000 gallon water tank.

In the Spring of 2024, members of the fire department initiated a capital campaign initiative through its tangent non-profit association to replace its outdated self-contained breathing apparatus. The estimated cost for this project is $80,000.

Rockland Fire and EMS Department

The Rockland Fire and EMS Department is currently the only career department in Knox County that delivers both fire protection services as well as emergency medical transport services. Until 2023, the department operated with three shifts that comprised an average 56-hour workweek. The city added a fourth shift, which increased the total career staffing to 21, which includes the chief. This arrangement has five personnel assigned to each shift, and equates to a 42-hour workweek over the course of an eight-week cycle. Many departments in Maine followed this trend in an effort to retain current employees, provide a better work-life balance for seasoned personnel, and to be used as a recruitment tool in enticing potential new employees onboard when vacancies occur.

Like Camden, the Rockland Fire and EMS Department can be classified as a combination department as there is a contingent of on-call fire fighters. The members of the call company are eligible to work as per diem fire fighters when their personal schedule allows. This opportunity is seen as a win-win situation for the department and the city collectively, where the shift strength can be augmented using Rockland's call fire fighters.

The department now has at its disposal, a remote control "Drone." This device can be used for a multitude of scenarios, such as searching the coastal waters for people in

distress, locating lost hikers, monitoring fire advancement and the like. This vital tool is made available to other neighboring public safety departments when needed.

Since 2015, Rockland has been awarded two Federal Emergency Management Agency (FEMA) Assistance to Fire Fighter Grants (AFG). One grant in 2018 for $217,591, and another in 2021 for $9,738. This category of Federal funding is directed towards improving the department's operational readiness and personnel safety.

The fire department was given the go ahead to place an order for a new pumper in 2023.

Rockport Fire Department

Since 2015, Rockport has put into service two new custom style four-door pumpers, one classified as a rescue pumper designed to carry an array of extrication tools. The town is awaiting delivery of a mini-pumper that is set to arrive sometime in the second half of 2024. Aerial Ladder service for Rockport is available from either Rockland or Camden, effectively negating the need for Rockport to acquire its own ladder truck.

The Rockport Fire Department is advancing its status on several other projects. In late 2023, ground was broken where a new $3.7 million four-bay fire station is being constructed directly behind the current West Rockport station.

Two career fire fighter/EMT positions were created at the annual town meeting held in June of 2023, and by October the new employees were assigned their duties. The scheme is to have one fire fighter/EMT on duty every day from 7:00 AM to 6:00 PM. The fire fighter/EMTs work a rotating schedule of four days on followed by four days off. As of mid May 2024, the Rockport Fire Department began responding to emergency medical calls during the hours of 7:00 AM to 6:00 PM, when one of the full-time fire fighters is on duty.

The approved fiscal 2025 budget includes new money to hire additional personnel with the intent of having two-career fire fighter/EMTs, one being a Paramedic, on duty around the clock to staff and operate a municipally operated emergency ambulance service, effectively moving away from the for-profit contract service the town has relied upon for more than a decade. The town had already ordered a new ambulance and is awaiting delivery. It is believed that Rockport will have its own ambulance service in place around the beginning of 2025.

The fire department has also acquired an off-road utility vehicle (UTV). The unit is stored in a box-style trailer and can be transported throughout the region. Its general mission is for wilderness rescue and wildland fire fighting. The trailer was purchased with donations from the Coastal Mountain Land Trust, the Maine Water Company and private citizens.

St. George Fire Department

The concept of the mini-pumper, which has been taking hold across the country, was the choice the St. George Fire Department made when designing the new Engine #2. The 2021 apparatus features a 1,500 gpm pump and a water tank that holds 400 gallons of water along with 15 gallons of fire fighting foam. At this time, this is the second of three mini-pumpers to be introduced in Knox County. Friendship and Camden are the other communities that have procured similar style vehicles.

Although St. George has three fire stations, the Port Clyde station does not currently house any apparatus, as there are no qualified personnel living or working within that section of town.

The project at hand for 2024 is to order a large capacity tanker with a 1,500 gpm pump and 3,000-gallon water tank on a 10-wheel commercial chassis. This will replace the 500 gpm, 1,800 gallons of water, 1990 Tank #2 housed at the Tenants Harbor station. The anticipated cost is approximately $550,000 and will require 550 workdays before being completed.

The town of St. George experienced a major fire in September 2023, and in a post-incident statement, the fire chief reported that the department had just nine fire fighters from the St. George Fire Department initially respond to that large loss fire. Since that time, a number of residents came forth and applied to become new members of the department. Six new fire fighters enrolled in the annual 2024 Fire Fighter I and II program undertaken by the Knox County Fire Training Academy.

South Thomaston Fire Department

The incumbent fire chief was promoted from his deputy chiefs' position in 2022. Earlier that year, South Thomaston voters approved funding to purchase two new apparatus. One vehicle is a four-door, light-duty rescue truck that carries the fire department's assemblage of small tools and equipment not otherwise carried on the pumpers. The other vehicle is a large capacity, dual-purpose pumper-tanker, with a pump capable of delivering 1,500 gpm, and a water tank capacity of 2,650 gallons. The town is due to receive these vehicles sometime in the second half of 2024.

The South Thomaston Fire Department was awarded a FEMA grant of $53,809 in 2021. These matching funds were used to enhance fire department operational readiness and fire fighter safety.

Thomaston Fire Department

In 2023, the town of Thomaston hired an architectural firm to conduct a feasibility study of its fire and EMS operations and to configure a conceptual fire and rescue building to replace an aging and outmoded facility. At the June 2023 town meeting the residents voted to designate a parcel of town-owned land along Route #1 to locate a new public

safety facility. The preliminary cost estimates to construct a 15,000 square foot fire, EMS and EMA building were in the realm of $8 million.

The operational component of that study included a recommendation to develop a capital improvement program. Furthermore, the report went on to suggest the town could eventually reduce the number of pumpers from three to two, but plan on replacing the 2003 quint (combination pumper/ladder truck) at the end of its expected life.

Thomaston does not possess extrication tools. The fire department has a cooperative agreement with Rockland, Warren, and South Thomaston who will send their equipment to Thomaston when the need arises.

In May of 2024, the incumbent fire chief announced his retirement, which took effect at the end June.

Union Fire Department

Until recently, the Union Fire Department and the Union Ambulance Department were separate municipal entities. The chief of the ambulance department was also the deputy fire chief, and with the passing of Union's fire chief in 2023, the deputy chief was charged with managing the two departments, which effectively combined both into a single public safety department now known as the Union Fire-Rescue.

In 2023, the fire department decommissioned a 1979 pumper. Eliminating this apparatus provided sufficient room in the apparatus bay for the Union Fire Rescue Department to add a second ambulance to the fleet. The department will be pursuing the acquisition of a new rescue-pumper with process beginning in mid 2024. It may take as long as four years to receive delivery of the new apparatus.

In 2012, the Union Fire Department pursued and achieved a superior "Public Protection Classification (PPC)" from the "Insurance Services Office (ISO)" by demonstrating its ability to flow sufficient quantities of water for fire suppression evolutions. The improved ISO rating resulted in a reduction of fire insurance premiums for some property owners in town. This laudable accomplishment was valid for a period of ten years. The fire department is currently assessing the need to revisit this situation with the intent of reconfirming its alternate water supply delivery capability so that it is in compliance with ISO's metrics.

Vinalhaven Fire Department

Vinalhaven is a remote island community that consists of 26.5 square miles of land and has a year round population of approximately 1,300. According to the town's comprehensive plan, it is believed that the summer population swells to almost 5,000 inhabitants. The concentrated area of the community is serviced by a quasi-municipal water system that includes 26 pressurized fire hydrants.

The Vinahaven Fire Department is headed by a career fire chief, who has had full-time status for 20 years. In addition to being the fire chief, the incumbent is also cross-trained as a certified EMT at the "Advanced" level, and responds to medical emergencies along with the team of the Vinalhaven Ambulance Department's EMTs. Of note, the full time ambulance director recently achieved his credentials as a certified Fire Fighter II.

In 2023, the Vinalhaven Fire Department responded to 106 calls for service. The department currently has a roster of 27 members, of which 16 are active and includes five new personnel who were enrolled in an on-island 84-hour basic fire fighting program that was administered by the Maine Fire Service Institute. This achievement increases the list of members that are qualified as interior fire fighters to 11.

The town is anticipating the delivery of a new pumper that will replace a 39-year old truck sometime in late 2024 or early 2025.

Waldoboro Fire Department

Although Waldoboro is located in nearby Lincoln County, the fire department is a member of the Knox County Mutual Aid Association. Waldoboro routinely responds to fire related incidents within Knox County. Perhaps the most significant and notable enhancement within the Waldoboro Fire Department in the past eight years is the acquisition of a new 107' rear-mount aerial ladder that is equipped with a 1,500 gallon per minute pump and 500 gallon water tank. In the past, Waldoboro had always purchased used aerial ladder apparatus. The Waldoboro aerial ladder is one of five that are strategically located throughout Lincoln County, and one of four when included in the inventory of ladder trucks that serve the 365 square miles of land in Knox County.

The town does not have a large capacity tanker truck, as many other departments throughout the region are so equipped. The Waldoboro Fire Department's belief is that their ladder truck is part of a regional approach to the equipment needs of the area, which negates the rationale for them to retain a tanker. Their closest mutual aid communities of Warren, Jefferson Washington, Union and Friendship each have tankers, and are enlisted in Waldoboro's deployment plan.

In 2023, due to a reduction in the number of available on-call fire fighters, especially during the day, the fire department approached the town requesting funds and approval to hire two fire fighters for daytime coverage. That initial request to staff the fire station during the weekdays was denied.

Warren Fire Department

The position of fire chief in Warren used to be full-time. However, the job was reclassified to part-time when the prior chief retired. The fire department's next pursuit in its apparatus replacement plan is to purchase a mini-pumper, a concept that is making great strides throughout Knox County and beyond.

Washington Fire Department

In 2017, the Washington Fire Department purchased a new conventional pumper for its Engine #1, which replaced a 1984 model. In 2020, the department put a new tanker into service that carries 3,000 gallons of water and has a 400 gpm transfer pump. The department is attempting to replace a 41 year-old vehicle that is equipped with a breathing air compressor capable of refilling air bottles on the site of an emergency incident. The department is pursuing federal grant opportunities that highlight the value as a regional need, which typically has a better chance of being funded. Due to Washington's location on the far reaches of Knox County, the Washington Fire Department is also aligned with its counterparts in neighboring Lincoln County.

A GAUGE IN MEASURING A COMMUNITY'S FIRE PROTECTION

The "Insurance Services Office" (ISO) - "Fire Suppression Rating Schedule" - Public Protection Classification" (PPC)

(Note: The following passage is from ISO's PPC documents)

The Fire Suppression Rating Schedule recognizes fire protection features only as they relate to suppression of first alarm structure fires. In many communities, fire suppression may be only a small part of the fire department's overall responsibility. ISO recognizes the dynamic and comprehensive duties of a community's fire service, and understands the complex decisions a community must make in planning and delivering emergency services. However, in developing a community's PPC grade, only features related to reducing property losses from structural fires are evaluated. Multiple alarms, simultaneous incidents and life safety are not considered in this evaluation. The PPC program evaluates the fire protection for small to average size buildings. Specific properties with a "Needed Fire Flow" (NFF) in excess of 3,500 gallons per minute (GPM) are evaluated separately and assigned an individual PPC grade.

A community's investment in fire mitigation is a proven and reliable predictor of future fire losses. Statistical data on insurance losses bears out the relationship between excellent fire protection – as measured by the PPC program – and low fire losses. Some insurance companies use PPC information for marketing, underwriting, and to help establish fair premiums for homeowners and commercial fire insurance. In general, the price of fire insurance in a community with a good PPC grade is substantially lower than in a community with a poor PPC grade, assuming all other factors are equal.

The following table illustrates the PPC for each of the communities that are within the Knox County Mutual Aid Association. Typically, those communities of rural character, that are without municipal water systems, that engage in minimal training scenarios annually, that consistently experience a limited number of qualified fire fighters that respond to fires, and other variables, will result in a poorer classification. Many rural communities may not be able to afford nor justify expending large sums of money in an effort to provide high quality fire protection. Each community assess the advantages—or benefits, and disadvantages—or costs, associated with what level of service the community can afford and what level of service is practical based upon a concise risk assessment.

The following table lists the PPC for each community within the Knox County Mutual Aid Association:

Community*	Public Protection Classification	Year PPC Completed
Appleton+		
Camden	4/4X	2018
Cushing+		
Friendship	8B/10	2017
Hope	9/10	2022
Islesboro+		
Lincolnville	9/10	2023
Matinicus	10	-
North Haven+		
Owls Head	5/5Y	2018
Rockland	3/3X	2018
Rockport	4/4Y	2018
St. George	6/10	2015
South Thomaston	8B	2017
Thomaston	4/4Y	2018
Union+	Pending	-
Vinalhaven	5/5Y	2018
Waldoboro	5/5X	2019
Warren	6/10	2014
Washington	6/10	2015
Isle au Haut	10	-

*This table is for illustrative purposes only.

+ The highlighted communities do not have their PPC posted in this table, as the actual ISO document requested for this project was not furnished. It is assumed the rating for Isle au Haut and Matinicus are both 10 as there is no organized fire department on these islands.

The PPC classification numbers are interpreted as follows:

- Class 1 through (and including) Class 8 represents a fire suppression system that includes a Fire Suppression Rating Schedule (FSRS) creditable dispatch center, fire department, and water supply.

- Class 8B is a special classification that recognizes a superior level of fire protection in otherwise Class 9 areas. It is designed to represent a fire protection delivery system that is superior except for a lack of a water supply system capable of the minimum FSRS fire flow criteria of 250 gallons per minute (GPM) for two hours.

- Class 9 is a fire suppression system that includes a creditable dispatch center, fire department but no FSRS creditable water supply.

- Class 10 does not meet minimum FSRS criteria for recognition, including areas that are beyond five road miles of a recognized fire station.

"Split Classification"

- The first class (e.g., “6” in a 6/XX) applies to properties within 5 road miles of a recognized fire station and within 1,000 feet of a fire hydrant or alternate water supply.

- The second class (XX or XY) applies to properties beyond 1,000 feet of a fire hydrant but within 5 road miles of a recognized fire station.

- Alternative Water Supply: The first class (e.g., “6” in a 6/10) applies to properties within 5 road miles of a recognized fire station with no hydrant distance requirement.

- A community formerly displayed as a split 6/9 classification are now a split 6/6X classification; with the "6X" denoting what was formerly classified as "9".

- Similarly, a community formerly graded as a split 6/8B classification are now a split 6/6Y classification, with the "6Y" denoting what was formerly classified as "8B".

- Communities graded with single “9” or “8B” classifications will remain intact.

ON THE HORIZON

OSHA REGULATIONS:

The Occupational Safety and Health Administration (OSHA) recently announced plans to revise the outdated and scope-limited Fire Brigades Standard, 29 CFR 1910.156. The proposed new standard will be titled “Emergency Response” and aims to include emergency responders, including fire departments, EMS agencies, and technical search and rescue teams. It will also govern responders who work other jobs in commercial or industrial settings but are activated as part of a Workplace Emergency Response Team when an incident occurs in the facility. This anticipated standard will likely impact fire and EMS services in the state of Maine once adopted.

OSHA has published an article regarding the anticipated Standard in a "Notice of Proposed Rulemaking (NPRM)." A "NPRM" is a public announcement made by a U.S. federal agency when it wants to change, remove, or add a rule or regulation. It's part of the rulemaking process and is similar to a first draft of a regulation. The NPRM explains the agency's plan to address a problem or achieve a goal, and it's published in the Federal Register to notify the public and give them the chance to comment. The comment period for the proposed Emergency Response Standard closed on July 22, 2024.

This article is a brief overview of many of the standards mentioned in the proposed rule and is not meant to be an exhaustive analysis of each section. The highlighted segments are included to portray the variety of areas the rules would cover and the significant work that may be required of some services to comply.

This article also will not explore the details of who is legally obligated to comply with OSHA standards. This varies from state to state and is complicated by a variety of factors. It should also be noted that in some circumstances, volunteer agencies may be covered by OSHA standards. Regardless of whether OSHA has legal authority over a particular state or service, there is an argument that they set a standard that could be indirectly applied to everyone. This may be particularly true after an incident has occurred and no other standard exists.

The general purpose of the proposed rule is to reduce emergency response team member injuries and fatalities. The NPRM document begins with an impressive section of statistics highlighting the dangers emergency responders face and the need for standards to reduce the impact of these injuries and deaths. The rule is specific to protecting responders and does not directly apply to medical care, outcomes or safety as they relate to patients.

Some of the specific sections of the proposed standard include:

- **Emergency response plan (ERP).** Agencies will be required to have a written program to ensure they are prepared to respond to, and operate safely in, the

emergency and non-emergency situations that are likely to occur in their primary response area. The ERP is intended to provide for the occupational safety and health of team members and encompass all aspects of emergency response, many of which are outlined below.

- **Vulnerability assessment of hazards.** Agencies must assess their primary response area to identify the types of calls they may respond to. Resources in the plan must be matched to these hazards and the plan should identify mutual aid resources to be called when the agency cannot mitigate a particular hazard.

- **ERP tiers, types and levels.** The agency must identify the various tiers, types and levels of responders covered by the ERP. Several sections of the proposed standard require the agency to identify training, evaluation, qualifications, duties and capabilities of responders based on these terms. One size does not fit all.

- **Team involvement with the plan.** The Emergency Response Plan should be developed, implemented, reviewed and updated with involvement from team members. OSHA identifies that front-line responders have valuable insight into the work process particularly as it relates to safety.

- **Medical and physical requirements.** The proposed standard specifies that responders will be required to meet medical and physical requirements based on their type and level of service. This section is extensive and pays particular attention to cardiovascular health.

- **Behavioral health and wellness resources.** Agencies would be required to offer team members services that include diagnostic assessment, short-term counseling, crisis intervention and referral to additional resources. Records arising from any use of these resources must be kept confidential.

- **Health and fitness program.** Team members should have access to health and fitness programs that help them maintain fitness for duty and to prevent work-related illness.

- **Training program.** A comprehensive training program must be in place to include initial and ongoing training as well as skills checks at appropriate intervals. All training and assessments will be based on tiers, types and levels of providers employed. The program must detail instructor qualifications, member evaluation methods, and assurances that team members will not be tasked with duties until they demonstrate the skills and abilities to safely complete them.

- **Facility safety.** OSHA understands that fire and EMS responders spend significant time in stations between calls and requires that these facilities also be safe. The section details the need to provide adequate spaces to decontaminate, maintain and store PPE and other equipment separate from living quarters. It also lists requirements for fire alarms, sprinkler systems, carbon monoxide detectors

and equipment to prevent vehicle exhaust from entering sleeping and living areas. And yes, they even set standards for fire pole safety.

- **Personal protective equipment (PPE)**. Significant attention is paid to the provision of PPE to responders as well as training, testing, maintenance, cleaning and disposal of the supplies and equipment.

- **Vehicle safety.** Highlighting the high numbers of fire and EMS responders injured and killed in vehicle crashes, OSHA proposes broad-reaching standards related to maintenance, inspection and testing of vehicles. The standards also outline important benchmarks in training and operation of vehicles, and the policies that should be in place to cover both. OSHA even settles the debate about the proper name of a legendary fire prevention character when it highlights the need for procedures to ensure the safety of occupants that are not able to be belted in a seat. OSHA notes that mascots such as *Smokey Bear* may not be able to be seat belted in when riding on a vehicle in a parade! (Note they did not call him Smokey <u>the</u> Bear?)

- **Incident Management System.** To align with the National Response Framework, OSHA will expect Emergency Response Plans to contain language about implementation, training and use of the Incident Management System. An emphasis is placed on provider safety monitoring and reporting during incidents.

- **Respiratory protection.** Training, equipment and policies related to responder respiratory protection have long been a major area of concern for OSHA and the proposed Emergency Response standard will continue that emphasis.

- **Communication.** Language in the proposed rule encourages reliable communication between dispatch centers and responders including monitoring of on-scene radio transmissions to maintain safety and respond to any on-scene responder emergencies. The rule also calls for interoperability between mutual aid resources.

FOREVER CHEMICALS - PFAS:

Per- and polyfluoroalkyl substances (PFAS) are a diverse group of thousands of chemicals used in hundreds of types of products. PFAS are a known carcinogen, and within the fire service, of particular concern is the use of PFFAS in fire fighter turnout gear. These ensembles contain PFAS, as PFAS have been found to be effective in resisting heat.

In March 2024, the City of Concord, New Hampshire appropriated more than $300,000 to change out 92 sets of turnout gear that are known to contain PFAS. By the end of this year, the city expects to have the contaminated gear replaced with new, non-toxic

personal protective bunker gear. The ultimate goal of this endeavor is to eventually provide two sets of PPE for each member of the department.

The fire departments within Knox County should address this important situation collectively in an effort to create the safest workplace environment possible for its fire fighters.

PROFESSIONAL DEVELOPMENT / SUCCESSION PLANNING:

Who will be the next chief officer(s) and company officer(s) in your department? Is your agency, your community committed to fostering, mentoring and grooming key personnel needed to manage not only today's public safety departments, but also consideration to include tomorrow's vision and needs as well.

As required by the State of Maine Bureau of Labor, we must train and qualify personnel in a variety of skills in order to operate at emergency incidents. We do that reasonably well with regard to psychomotor, hands-on, skill-building fire fighter training. Where we need to broaden our educational pursuits is within the more cognitive programming that leadership roles require. Fire officer training is an area that could use more attention and be part of a formal instructional delivery that would be imparted to fire fighters who aspire to higher levels within an organization.

Although the Maine Fire Service Institute (MFSI) and Southern Maine Community College (SMCC) are the lead agencies in Maine offering higher-level cognitive fire service training opportunities, these programs may not be readily accessible or attainable for all aspirants.

The opportunity to provide local fire officer education programs should be explored.

RECRUITMENT - ADULT EDUCATION PROGRAM:

On May 9, 2024, the Five Town Adult & Community Education Program, held at the Camden Hills Regional High School, offered a one-night seminar entitled "Firefighters Needed." The goal of this outreach program was to provide an overview of what the fire service is all about with an ulterior motive of finding new recruits that would be interested in joining their local department. Although the initial session was lightly attended, a repeat program is scheduled for October 2024.

FIXED FACILITIES:

The need for fire and EMS facility upgrades, retrofits and perhaps replacement was not part of this project. However, a collective needs assessment eyeing the current and future requirements of public safety facilities should be considered a priority assignment. With

some of the communities having stepped into around the clock staffing models, some of the fire and EMS stations may not be conducive to housing personnel 24 hours a day, let alone be compliant with the industry's best practices, and be code compliant. As mentioned, Thomaston has begun the process of replacing their fire and EMS station, while Rockport is in the midst of constructing a replacement building in West Rockport.

Those communities that may be contemplating the need to upgrade or replace their public safety facilities should explore the opportunity to secure grant funding. During the past couple of years, a number of Maine communities have either been granted or are in-line to be granted federal funds to build new fire and EMS facilities. These appropriations must be applied for and typically provide but a portion of the expected cost of construction. Interested communities will need to contact the Maine Senator's Office to learn about "Congressionally Directed Spending" opportunities. Some of the communities that have been tapped to receive funding for new fire and rescue station construction projects include Belfast, Bath, Bradford, Brownfield, Hancock, Limerick, Newburgh, North Anson, Plymouth, Randolph, Sinclair and Van Buren.

The most recent round of grants, announced in July 2024, has the Island Falls Fire and Ambulance Department in line for $847,000 that will go towards the expansion of their station. The town of Belgrade will see a $4.8 million appropriation come their way to construct a new fire station, Easton $3 million, and North Berwick $3.4 million for a combined fire and EMS facility.

OPERATIONAL CONSIDERATIONS

- Collaborative Deployment Protocols - also known as - "Run Cards"

The collective group of Knox County Mutual Aid Association (KNMMA) superior fire officers should coalesce and conduct a holistic review and revision of the manner in which mutual aid and automatic aid resources are dispatched. Currently, it appears that when two or more fire departments are dispatched to an incident, it is left to the discretion of the responding departments at that moment in time to send what is assumed the appropriate apparatus.

The protocols should be amended and refined to be more definitive in a prearranged manner so as to eliminate guesswork and ensure the appropriate apparatus is sent to the call, and not to deplete or drastically reduce resources in any one community. A revised method of dispatching apparatus should identify what apparatus is to be sent from each community when called upon. Is it one pumper from Hope, a tanker from Owls Head, an aerial ladder from Camden, or a forestry unit from Washington? A concise and methodical deployment script to be utilized by the dispatch center should be considered fundamental.

To further the discussion of automatic and mutual aid response, department leaders should look at the benefits of functioning as a "company" of fire fighters when responding out of one's jurisdiction. More and more fire departments are opting to procure multi-seat fire apparatus designed to carry more than just two fire fighters, which is a limiting factor with two-door conventional chassis apparatus. In many cases, apparatus are responding to out of town incidents with a single operator, and are met by personnel arriving at the incident in their personal vehicles. Administrators should consider having a prescribed number of fire fighters board an apparatus before responding out-of-town. For those departments that operate two-door apparatus that can only seat two fire fighters, a smaller department vehicle can transport additional personnel from the fire station. For consideration and as a rule of thumb, for every responding engine and ladder, there should be a contingent of three to four assigned fire fighters, for tankers there should be no less than two.

Another suggestion regarding radio communications: The primary radio frequency utilized to notify Knox County fire and EMS departments at times is overburdened when multiple incidents are ongoing. It may behoove the collective agencies to devise a systematic approach to moving radio traffic for certain types of incidents to a separate working frequency. Not only should the incident commander have the authority to move communications off the primary channel, so too should the dispatcher.

- The development and implementation of countywide "Rapid Intervention Teams" (RIT)

The region's fire departments should embrace and implement the concept of Rapid Intervention Team (RIT). Fire departments are often engaged in emergency activities that present a varying degree of risk to fire fighters, depending on the incident. The objective is to have a fully qualified rescue team on scene and in a ready state to deploy for rescuing injured and imperiled firefighters. This procedure should be considered for all incidents where personnel are subject to hazards that would be considered potentially dangerous to life and/or health or subject to danger from equipment failure or sudden change of conditions. A RIT should be established on all structure fires that have grown beyond the incipient stage, other incidents where personnel are subjected to hazardous environments or when the incident commander deems it necessary.

The concept of RIT can be tied directly to Maine's Bureau of Labor Standards Two-In/Two-Out Rule. This requirements has—at a minimum—two fire fighters waiting in full protective turn out gear outside a fire building while two other firefighters initiate fire attack or search and rescue operations inside the fire building.

- The development and implementation of a "Tanker Task Force"

The KCMAA should develop and implement a predetermined response protocol specifically designed to address the needed fire flows for the rural areas that are beyond access to pressurized fire hydrants. The purpose is to have fire apparatus with large capacity water tanks operate in unison at a fire transporting water from a source to a fire scene uninterrupted.

The establishment of a strike team or task force would alleviate guesswork before a fire occurs in the outlying areas. The system would require planning, policy statements, training, and implementation. This response protocol may be in addition to or a precursor of achieving the requirements of ISO's alternative water-supply system criteria. With so many new tankers having been purchased recently, this may be an opportune time to revisit this recommendation. The KCMMA has identified this as a project to pursue which was recommended in the 2015 report.

- Alternative Water Sources

Due to the fact that are vast areas of Knox County that are not serviced by a municipal water distribution system with interconnected fire hydrants, static water sources and fire apparatus designed to transport water to the scene of a fire are crucial assets. The collective fire departments should develop strategic water source and delivery plans, and conduct requisite training scenarios that could eventually earn an acceptable grade from the Insurance Services Office. This project may be viewed as a major undertaking, but the outcome of a well-grounded definitive countywide plan could be of significant benefit. This recommendation goes hand-in-hand with that of the tanker task force.

- Geographic Information System (GIS) Mapping

The KCMAA should consider approaching the Knox County Emergency Management Agency to see if it would be feasible to map out the location of pressurized fire hydrants, draft sites, dry hydrants, cisterns and any accessible water source that could be utilized in fire suppression, using the county's GIS service. This information would then be incorporated into the County's computer aided dispatch program. This information could be strategically beneficial for incident commanders who are charged with coordinating fire companies in fire fighting operations. Knowing where water sources are located beforehand and having the ability to guide responding companies directly to a source can be a crucial timesaver.

- Cooperative or Group Purchasing Program

There is no true mechanism in place for the fire departments to purchase goods and services collectively. With exceptions, most of the departments' current method of procurement is done on an individual basis. There may be cost-savings, timesavings, and standardization realized if the departments pooled their resources and purchased these essentials through a competitive bidding process. This would require cooperation, coordination and effort to get all the players to agree to how the program should be administered. As one local example of the value of cooperative purchasing is the purchase of two-way radio communications equipment that was handled at the county level. Pre 2015, the need to upgrade the region's radios and pagers was endeavored by the Knox County EMA office. In 2010 the County bought approximately 150 pagers for multiple Knox County agencies, and saved about $30,000. In 2011, another purchase of 242 mobile and portable radios, and pagers was made. This consisted of 30 agencies across five Maine counties and saved $60,086 over retail. A year later, 1,331 radios and pagers for 12 counties and 50 agencies were purchased, which resulted in a savings of $260,340 over retail.

The County should be encouraged to explore the feasibility of creating a "Council of Governments." The mission of a typical COG is to help communities save money and enhance operational efficiencies in many facets of municipal service delivery. COGs were created in order to develop consensus regarding regional needs and actions to be taken in solving area problems. COGs benefit the state by planning, coordinating, and overseeing the administration of state and federal programs, assisting local governments in handling tasks set by state regulations, providing a flexible network for effective regional action, and fostering cooperation that helps avoid duplication of efforts and thus helps take advantage of economies of scale.

Until such time that a regional approach to cooperative purchasing is achieved, the fire chiefs could present their Capital Improvement Plans (CIP) to the body of the KCMAA. The purpose would be to identify where certain items could be purchased collectively. Furthermore, sharing each department's CIP in a group forum may recognize areas where streamlining, cost sharing and cost avoidance can be achieved.

- Identify spare pumper

Fire apparatus has become exceedingly expensive and long delays in production time are impacting fire departments in their efforts to modernize their fleets. Some departments are now focusing on reducing the number of apparatus and replacing outdated vehicles with two older units for one new multi-functional apparatus.

There may be a collective value in retaining or procuring a pumper or other type vehicle that can swiftly be allocated to any one department that may experience the loss of a vital piece of equipment. The logistics and decisions that would be required to make this a reality may be difficult to maneuver through, as it can be just as political a mission as it can a be a logical pursuit.

- Hire a Regional Fire & EMS Coordinator/Administrator

There may be value in having a single office that assists the collective fire departments with the host of functions that comes with managing a consortium of public safety organizations. Instead of each community having to address the increased workload of the local fire or EMS chief, a centralized office of "coordinator" or "administrator" may be an efficient and effective way in which to address those burgeoning responsibilities. This could be a stand-alone position under the authority of the Knox County Mutual Aid Association or established within the county government structure such as the Emergency Management Agency.

New York has a system of county fire coordinators across the state who are charged with handling numerous emergency service related issues. In most counties, the County Fire Coordinator acts as a Regional Fire Administrator under the State Fire Administrator in times of activation of the Statewide Fire Mobilization Plan. County Fire Coordinators also provide assistance to the Fire Chief or other incident commander at scenes of emergencies in which mutual aid from other jurisdictions is requested.

The Fire and EMS Coordinator may serve within the incident command system as a Liaison Officer, or may provide resources requested by the incident commander and perform other duties as required by local policy and operational mutual aid guidelines.

York County, Maine created such a position in 2019, which was a first for the State of Maine. The town of Harpswell, Maine also created a version of a fire coordinator to assist in managing three separate town fire associations.

For Knox County, the list of responsibilities assigned the coordinator could be infinite, however, the most pressing issues currently are:

- ✓ Recruitment and Retention
- ✓ Compliancy with Maine's Bureau of Labor Standards
- ✓ Safety Officer
- ✓ Cooperative/Group Purchasing
- ✓ Universal Policy Statements
- ✓ Specialized Teams Coordinator
- ✓ Training Program Manager
- ✓ Special Projects Facilitator
- ✓ Grant Writer
- ✓ Accountability System
- ✓ ISO Public Protection Classification Program
- ✓ Manage a Collective Fire Department Medical Program (NFPA #1582)

(SEE APPENDIX "A")

Considerations: Island Specific Fire Departments

Pre-Planning

The island communities of Knox County are faced with unique and challenging fire protection circumstances. Fire and rescue assistance from other sources are not readily available.

During the height of the 2023 summer season in the town of New Shoreham, Rhode Island, more commonly referred to as Block Island, the popular island retreat experienced a major nighttime fire in an occupied lodging facility. The incident quickly exceeded the capacity of island's fire fighting force.

Knowing full well that the department was faced with significantly challenging hostile fire scenarios, the Block Island Fire Department undertook a campaign to be better prepared to mitigate a major fire. The department had recently updated its emergency pre-plan that identified specific land-based fire departments in its scheme to deploy multiple companies to the island in the event of a large-scale fire. Not only was the script approved by all the agencies involved, the plan was carried out in a full scale drill that had fire apparatus and fire fighters transported to the island by ferry and airplane to execute a drill in real time.

According to accounts, this "rehearsal" was key to the successful fire fighting operation that fateful summer night. Although the historic hotel was lost, the fire did not extend to other buildings in the tightly packed neighborhood.

The island communities should develop a thoroughly vetted pre-fire plan that methodically identifies a course of action that should be followed during moderate to large-scale incidents that require off-island public safety resource assistance. The fire chiefs may want to reach out to the Block Island Fire Department in an effort to follow their template in developing their own specific action plan. To reiterate, the intent is to have a definitive action plan that will guide all the key players in a well coordinated, occasionally practiced exercise.

Rural Water Supply

The island towns in particular may want to explore the benefits of the self-filling vacuum tanker concept. The "vacuum tanker" can be filled at up to 2,000 gallons of water per minute and does not require a fire apparatus pumper at draft to accomplish the task. This style tanker can self-fill from up to three suction inlets on the vehicle, using almost any accessible alternative static water source. The vacuum tanker used for fire suppression is quite similar to the "septic pump truck" that is used in removing waste from in-ground septic tanks.

The descriptive word pump is not necessarily a correct depiction. The pump actually creates a vacuum within the truck-mounted tank, which creates a vacuum that causes the water to be drawn through the suction hose and into the water tank.

The town of Islesford, Maine—The Cranberry Isles, has two such tankers, with one in each of its two fire stations on two separate inhabited islands within the archipelago. Citing a minimal number of personnel that may be available to suppress a fire, and keeping the size of the fleet of apparatus manageable, the efficiency of the vacuum tanker was a logical choice for the fire department.

Not only does their most recent tanker purchased in 2020 have the requisite vacuum pump, it is also outfitted with a rated fire pump. This feature allows the tanker to pump water and can be used to fight fire with pre-connected fire attack hose lines, making this apparatus multi-functional.

EMERGENCY MEDICAL SERVICES

EMERGENCY MEDICAL SERVICES

The communities within Knox County are served by a variety of emergency medical service delivery systems. The following descriptions provide an overview of each of those.

Appleton

The town of Appleton contracts with town of Union for emergency ambulance service. There is an Ambulance Advisory Committee that is made up of representatives of the three towns that the Union ambulance serves. The committee meets on a quarterly bases with the intended purpose of allowing for continued open dialogue and operational understanding of the service as it evolves and steadies for the future.

The number of calls exclusively for the town of Appleton:

Year	Appleton - Calls for Service
2023	94
2022	87
2021	84
2020	78
2019	78

Camden

The town of Camden contracts with a for-profit ambulance company, North East Mobile Heath Services (NEMHS). The ambulance service is based at a facility in Rockport.

In 2023, acting upon a recommendation that was the result of a study conducted by an independent EMS consultant in 2019-20, the Camden Fire Department initiated a first-responder program where the duty crew now responds to EMS calls along with the ambulance. A new fire department mini-pumper was placed into service prior to the first responder program being implemented. The vehicle is outfitted with medical equipment as well as fire suppression tools and equipment.

North East Mobile Health Care Services - Camden annual calls for service

Year	Camden - Calls for Service
2023	1,188
2022	956
2021	916
2020	778
2019	932

Cushing

The town of Cushing operates its own on-call ambulance service with 13 members. In 2022, the town took delivery of a new four-wheel drive Type I ambulance. The ambulance is also equipped with a automatic CPR device.

The Cushing Ambulance may be the last service in Knox County that relies solely upon a cadre of committed EMS providers who are classified as on-call, where the EMS station is not staffed by a duty crew, a model most other ambulance agencies have migrated to. With the exception of Northaven, it appears that the Cushing Ambulance Service responds to the least number of EMS calls in mainland Knox County.

(From the Maine EMS website: "The Maine Emergency Medical Services Stabilization and Sustainability Fund"

Purpose of Funding

The 131st Legislature specifically defined, "The purpose of the program is to provide financial assistance… to emergency medical services entities at immediate risk of failing and leaving their communities without access to adequate emergency medical services…"

Maine EMS seeks to support this mission by ensuring that funding is used responsibly and sustainably. A primary objective is to ensure that funds are not used in a manner that creates a funding vacuum after the grant period, where recipient agencies have developed programming and/or on-boarded staff persons that cannot be sustained locally. To that end, Maine EMS will require that all EMS agencies receiving funding from this program provide evidence that they have contemplated the viability of the program(s) they implement using this funding.)

In 2023, the Governor of Maine signed into law, the "Maine EMS Stabilization Program," funded at $12 million. This is part one of a two-part program that is authorized to infuse a total of $31 million in support Maine EMS services. In 20024, Cushing was allocated $21,955.

Cushing EMS - Cushing annual calls for service

Year	Cushing - Calls for Service
2023	122
2022	158
2021	?
2020	?
2019	?

Friendship

The town of Friendship contracts with the town of Waldoboro for emergency ambulance service.

Waldoboro EMS is staffed around the clock typically with an on duty crew of four. The EMS chief, who is a paramedic, is assigned a "Fly Car," which allows him to respond to incidents to augment staff where additional personnel are needed or when a transporting ambulance is not readily available, yet emergency medical treatment needs to be initiated. The department consists of a full time chief and seven full time personnel. There are a number of part time employees who work regular shifts over the course of a two-week period. The third tier of personnel is categorized as per diem employees where they fill in gaps in the schedule. Waldoboro EMS responds to approximately 1,760 calls per year of which 320 are inter facility transfers.

Waldoboro EMS stores a cache of EMS equipment at the Friendship fire station that can be accessed by a core of First Responders that live in Friendship.

In addition to the Fly Car, the department operates one Type I ambulance and two Type III ambulances. The town has recently placed an order for two new Type I replacement ambulances.

In 2023, the Governor of Maine signed into law, the "Maine EMS Stabilization Program," funded at $12 million. This is part one of a two-part program that is authorized to infuse a total of $31 million in support Maine EMS services. In 20024, Waldoboro was allocated $69,310.

Waldoboro EMS - Friendship annual calls for service

Year	Friendship - Calls for Service
2023	121
2022	117
2021	86
2020	140
2019	144

Hope

The town of Hope is served by the North East Mobile Heath Services, a for-profit ambulance company.

North East Mobile Health Care Services - Hope annual calls for service

Year	Hope - Calls for Service
2023	108
2022	109
2021	94
2020	98
2019	71

Lincolnville

The town of Lincolnville is served by the North East Mobile Heath Services, a for-profit ambulance company.

North East Mobile Health Care Services - Lincolnville annual calls for service

Year	Lincolnville - Calls for Service
2023	259
2022	259
2021	231
2020	157
2019	177

Matinicus

Matinicus does not have an organized emergency medical service.

North East Mobile Health Services (NEMHS)

This Rockport based EMS contractor has served the towns of Camden, Hope Lincolnville and Rockport for about ten years. This EMS facility is currently staffed during the course of the day as follows:

1 Paramedic Unit 24 Hours/7 Days A Week - 06:00 AM-06:00 AM (the following day)
1 AEMT / Paramedic Unit 16 Hours/7 Days Per Week – 07:00 AM-11:00 PM
1 AEMT / Paramedic Unit 10 Hours/6 Days Per Week – 09:00 AM-19:00 PM

1 Paramedic Fly Car – As needed, but usually available 5-6 days a week.

1 AEMT/Paramedic Unit not staffed, but pressed into service if/when needed

In 2023, the Governor of Maine signed into law, the "Maine EMS Stabilization Program," funded at $12 million. This is part one of a two-part program that is

authorized to infuse a total of $31 million in support Maine EMS services. In 20024, North East Mobile Health Services was allocated $163,009.

North Haven

The town of North Haven operates a single 2015 Type III ambulance. The ambulance director for the town of Vinalhaven also serves as the director of the North Haven service. North Haven calls for service are recorded from January to December.

In 2023, the Governor of Maine signed into law, the "Maine EMS Stabilization Program," funded at $12 million. This is part one of a two-part program that is authorized to infuse a total of $31 million in support Maine EMS services. In 20024, North Haven was allocated a $15,000.

North Haven Ambulance Department annual calls for service

Year	Calls for Service
2023	32
2022	58
2021	44
2020	43
2019	49

Owls Head

The town of Owls Head contracts with the City of Rockland Fire and EMS Department for ambulance service.

Rockland EMS - Owls Head annual calls for service

Year	Owls Head - Calls for Service
2023	190
2022	175
2021	149
2020	127
2019	157

Rockland

The city of Rockland has provided Paramedic level ambulance service for decades. The Rockland Fire and EMS Department is deemed a "fire based EMS delivery system," which means the 21 full time members of the department are versed in both fire protection and emergency medical services. The department also has an on-call force

that is comprised of six active members who may or may not be certified as EMS providers.

Rockland retains three Type I ambulances, two that are 2016 models and one 2018 model. Rockland anticipates the arrival of its newest Type l ambulance in mid 2024. The fire chief is looking to keep the oldest unit that could be earmarked as a regional spare. As many of the area's smaller services only have one ambulance, having access to a spare is seen as a critical need.

In 2023, the Governor of Maine signed into law, the "Maine EMS Stabilization Program," funded at $12 million. This is part one of a two-part program that is authorized to infuse a total of $31 million in support Maine EMS services. In 20024, Rockland was allocated the highest amount allowed, $200,000.

Rockland EMS - Rockland annual calls for service

Year	Rockland - Calls for Service
2023	1,612
2022	1,401
2021	1,273
2020	1,278
2019	1,439

Rockport

The town of Rockport is served by the Northeast Mobile Heath Services, a for-profit ambulance company.

North East Mobile Health Care Services - Rockport annual calls for service

Year	Rockport - Calls for Service
2023	600
2022	558
2021	507
2020	373
2019	451

Rockport will be instituting its own municipal transporting ambulance service as a division within the town's fire department in late 2024 or early 2025. The town voters approved a fiscal 2025 operational budget for the new ambulance service of approximately $1.2 million. This will allow the Rockport Fire Department to maintain a roster of nine full-time fire fighter/EMT positions, including the chief, and have two personnel on duty around the clock.

In fiscal 2024, as a preemptive move and knowing the lengthy lag-time between ordering and taking delivery of emergency vehicles, the Board of Selectmen authorized the fire chief to purchase an ambulance.

St. George

The town of St. George provides it own municipal emergency medical transporting ambulance service. The move to bolster EMS in St. George occurred in 2023, when voters at the annual town meeting approved a measure that transformed the ambulance service from a volunteer association to a municipal department, staffed around the clock with at least two personnel. The maneuver also created four full-time Paramedic positions, one being assigned the duties of service chief.

The St. George Ambulance Department shares space with the fire department at the town's multipurpose building located in Tenants Harbor.

The ambulance department operates a single 2015 Type III ambulance, and a 2018 Sport Utility Vehicle (SUV) designated as a "Paramedic Fly Car."

In 2023, the Governor of Maine signed into law, the "Maine EMS Stabilization Program," funded at $12 million. This is part one of a two-part program that is authorized to infuse a total of $31 million in support Maine EMS services. In 20024, St. George was allocated $49,925. Earlier in the year, the department also received a separate $99,000 grant in an effort to bolster the Community Paramedicine Program.

St. George Ambulance Department annual calls for service

Year	Calls for Service
2023	441*
2022	347
2021	317
2020	294
2019	370

* This includes Community Paramedicine Program outreach calls

South Thomaston

The town of South Thomaston provides it own municipal emergency medical transporting ambulance service. The ambulance is staffed from 6:00 AM to 6:00 PM daily by two per diem emergency medical technicians. At night, members respond to the station from home, board the ambulance and deploy to the incident.

The department operates a single 2019 Type I ambulance.

In 2023, the Governor of Maine signed into law, the "Maine EMS Stabilization Program," funded at $12 million. This is part one of a two-part program that is authorized to infuse a total of $31 million in support Maine EMS services. In 20024, South Thomaston was allocated $41,784.

South Thomaston Ambulance Department annual calls for service

Year	Calls for Service
2023	260
2022	297
2021	259
2020	283
2019	202

Thomaston

The town of Thomaston provides it own municipal emergency medical transporting ambulance service. The fiscal 2024 budget included funding for a full-time ambulance chief. As part of the duties and responsibilities of this new position, the chief will be assigned ambulance coverage 36 hours per week, typically in three 12-hour segments. Furthermore, the townspeople voted to have around the clock ambulance coverage utilizing per-diem employees in conjunction with ambulance chief who also covers shifts. Personnel assigned to shift work are licensed to varying degrees, and there is not always a Paramedic on duty. Currently, the fire station is not designed to house an overnight duty crew. Those members assigned the night shift can respond to the fire station from their homes, but must live within a certain distance from the station in order to be eligible to work the night shift.

In 2023, the town of Thomaston hired an architectural firm to conduct a feasibility study of its fire and EMS operations and to configure a conceptual fire and rescue building to replace an aging and outmoded facility. The operational component of that study included a recommendation to eventually transition from the per diem EMT model, to a program where phasing-in the hiring of full time personnel as dual role EMT/fire fighters occurs. At some point along this progression would be the opportunity to merge the ambulance department and the fire department into one municipal agency under the direction of a full time fire and rescue chief.

The town operates a single 2017 Type III ambulance.

In 2023, the Governor of Maine signed into law, the "Maine EMS Stabilization Program," funded at $12 million. This is part one of a two-part program that is authorized to infuse a total of $31 million in support Maine EMS services. In 20024, Thomaston was allocated $68,832

Thomaston Ambulance Department annual calls for service

Year	Calls for Service
2023	451
2022	490
2021	416
2020	421
2019	366

Union

The town of Union provides it own municipal emergency medical transporting ambulance service. Additionally, Union also provides contractual emergency ambulance transport service to the towns of Washington and Appleton. There is an ambulance advisory board that consists of residents from the three towns, however, the service is under the authority of the Union town manager. The board meets routinely to discuss the administrative and operational aspects of the EMS service. Revenues collected for transporting patients to hospitals are credited against the ambulance's budget to effectively reduce the annual operational costs.

The Union ambulance is staffed with two personnel 24 hours a day. The town has one full-time Paramedic who works 24 hours straight followed by three days off. This work schedule equates to a 42-hour workweek. The other EMTs are per diem employees.

In 2022, the town applied for and was chosen for a pilot project entitled Emergency Medical Services "Informed Community Self Determination" program. The Union Fire Rescue Department wanted to use ICSD to address certain matters the provider service was experiencing in delivering EMS that was perceived as affordable to its neighboring towns on a contractual basis while enhancing the reliability of providing the highest level of care.

With the disposal of the town's oldest fire department pumper in 2023, a spot on the apparatus floor became available allowing for the inclusion of a second ambulance. The primary unit is a 2018 Type I, and the back-up unit, which is a recent acquisition, is a used 2015 Type III.

As previously mentioned in this report, the fire and ambulance departments have merged into a single department now known as the Union Fire-Rescue. The incumbent chief who is a Paramedic is also a certified fire fighter. The ambulance is staffed around the clock with two EMTs, and there is currently one full-time Paramedic municipal employee.

In 2023, the Governor of Maine signed into law, the "Maine EMS Stabilization Program," funded at $12 million. This is part one of a two-part program that is authorized to infuse a total of $31 million in support Maine EMS services. In 20024, Union was allocated $25,974.

Union Ambulance Department annual calls for service

(Note: The table below is the total number of calls for the three communities the ambulance serves, plus mutual-aid that Union provided other communities.

Year	Total Calls for Service
2023	613
2022	727
2021	598
2020	470
2019	507

(Of note, in 2022, there were 41 calls that had to be answered in Union by other mutual-aid EMS agencies as the Union ambulance was already committed to a prior call for service.)

The number of calls exclusively for the town of Union:

Year	Union - Calls for Service
2023	365
2022	395
2021	270
2020	224
2019	251

Vinalhaven

The town of Vinalhaven operates a municipal ambulance service, which is managed by a full-time director, who is an Advanced Emergency Medical Technician (AEMT), and has recently become a certified Fire Fighter II. The director works a fixed schedule of Monday through Friday 6:00 AM to 6:00 PM. The full-time fire chief is an AEMT, works a similar schedule and does respond to medical calls along with the ambulance director.

The department has two ambulances, a 2011 Type I, and a 2009 Type III. The calls for service are reported on a calendar year basis. At this time, the department roster does not contain any Paramedics. To augment the ambulance when needed, the medical professionals that are associated with the private non-profit Islands Community Medical Services will assist with urgent medical emergencies. This agency is based on Vinalhaven, but also treats patients from Matinicus and North Haven.

In 2023, the Governor of Maine signed into law, the "Maine EMS Stabilization Program," funded at $12 million. This is part one of a two-part program that is authorized to infuse a total of $31 million in support Maine EMS services. In 20024, Vinalhaven was allocated $26,712.

Vinalhaven Ambulance Department annual calls for service

Year	Calls for Service
2023	161
2022	187
2021	190
2020	164
2019	218

Waldoboro

The Waldoboro Emergency Medical Services is a municipal department that provides both emergent medical care and inter-facility transport service. The department is staffed around the clock and is contracted for service with the town of Friendship and a portion of the town of Jefferson. (See annual calls for service in Friendship)

In 2023, the Governor of Maine signed into law, the "Maine EMS Stabilization Program," funded at $12 million. This is part one of a two-part program that is authorized to infuse a total of $31 million in support Maine EMS services. In 20024, Waldoboro was allocated $69,310.

Warren

The Warren Ambulance is a municipal department, which is housed within the same building as the fire department. Two per diem personnel staff the ambulance during the daylight hours Monday through Friday, while on-call EMTs provide coverage nights and weekends.

The town operates a single 2015 Type III ambulance. In 2023, the town ordered a new replacement ambulance.

In 2023, the Governor of Maine signed into law, the "Maine EMS Stabilization Program," funded at $12 million. This is part one of a two-part program that is authorized to infuse a total of $31 million in support Maine EMS services. In 20024, Warren was allocated $37,505.

Warren Ambulance Department annual calls for service

Year	Warren - Calls for Service
2023	478
2022	500
2021	500
2020	417
2019	440

Washington

The town of Washington contracts with the town of Union Fire-Rescue for emergency ambulance service. There is an Ambulance Advisory Committee that is made up of representatives of the three towns the Union ambulance serves. The committee meets on a quarterly bases with the intended purpose of allowing for continued open dialogue and operational understanding of the service as it evolves and steadies for the future.

The number of calls exclusively for the town of Washington:

Year	Washington - Calls for Service
2023	139
2022	220
2021	225
2020	161
2019	164

OBSERVATIONS and CONSIDERATIONS - Emergency Medical Services

St. George and South Thomaston

Currently, the towns of St. George and South Thomaston are both managed by the same EMS director although the arrangement is not considered "sharing." The service chief position in St. George is a full-time municipal appointment. In neighboring South Thomaston, the position is considered part-time. Until recently, the same individual had also been the part-time service chief in Thomaston. To a degree, this has aligned the three separate agencies into a more interconnected arrangement, or perhaps what may be characterized as "functional consolidation."

Spare Ambulance

Cushing, South Thomaston, St George, Thomaston and Warren all operate with a single ambulance. The call volume for each community does not necessarily warrant adding a second in-service ambulance to any one community at this time. What is of concern is that if any one ambulance is placed out of service due to a mechanical failure or other reason, that community is left without a transporting ambulance, which places a burden on the other EMS providers.

The consortium of communities should consider the acquisition of an additional ambulance(s)—in all likelihood a used vehicle, which would be designated as a "shared" spare. The group would have to develop a memorandum of understanding, determine a financial arrangement, and find a station that would have room to house it.

Pay Parity

In an effort to level the playing field so that no one municipal EMS service in Knox County offers better hourly wages or financial bonuses than another, all in an effort to entice the part time workforce to gravitate toward the more lucrative opportunity, the EMS services that rely on per-diem employees should come to a collective agreement where wages are uniform among all ambulance services. In today's employee-centric environment, the lower paying service is typically at a disadvantage in meeting its staffing requirements.

Create a Shared Pool of Per Diem EMS Providers

Many of Knox County's emergency medical services that routinely staff their ambulances depend upon a group of people who are willing to fill open shifts when they are available earning an hourly wage and without access to a benefit package that typically comes with full time career status. There may be an opportunity to pool these EMS providers into a group that can be assigned to work in any number of those services that hire part time employees. The objective is to ensure that no one service cannot operate due to the lack of an on-duty crew assigned to a station.

North East Mobile Health Care—The four-town alliance

A single for profit provider, North East Mobile Health Care has been providing contract emergency ambulance service to the group of towns that includes Camden, Hope, Lincolnville and Rockport for approximately a decade. This model serves a year-round population of nearly 13,000 with a coverage area comprised of 127.50 square miles. Each community is assessed a yearly fee for service. Annually, this arrangement is predicated on the premise that each community will continue to engage the services of the contractor. To an extent, this pact is perhaps the closest example of a regional ambulance service in Knox County, despite it being operated by a private vendor. The Camden Fire Department began its "First Responder" program, augmenting the contract ambulance service in March 2023 and the Rockport Fire Department initiated its program in mid 2024.

With the advent of Rockport's quest to strike out on its own by establishing an E-911 emergency ambulance service, it remains to be seen what the financial impact and the service capacity will be on North East Mobile Health Care. In 2023, the emergency calls to Camden, Hope, Lincolnville, and Rockport totaled 1,631 calls. As an example, by extracting Rockport's 600 calls, the total for the three remaining communities would be 1,031 for the year. Over the past five years, the total average number of calls for the four towns was 1,764, and the average for Rockport was 498. That would result in a call volume for the five-year period for just Camden, Hope and Lincolnville of 1,266 calls for service.

Rockland Fire & EMS

The town of Owls Head contracts with the City of Rockland as its service provider for emergency medical transport services.

Union Municipal Ambulance Service and the relationship with the towns of Washington and Appleton

The relationship between these three communities where one is the service provider can be viewed as a model of cooperation and partnership. Instead of each community attempting to provide EMS on their own accord, having Union with an established municipal EMS department continue being the areas emergency ambulance service is a plausible enterprise.

In an effort to improve upon the level and reliability of ambulance service to the three towns, a significant increase in the proposed budget lead to a contentious debate where Washington and Appleton began looking at alternatives. This spurred the town of Union to enlist the assistance of a third party consultancy to help in quelling the disenchantment. The town secured a grant and a project entitled The Emergency Medical Services "Informed Community Self-Determination" (ICSD) endeavor was launched in August 2022. The results of this project lead to a better understanding of what was entailed in operating a successful, meaningful, high-quality service organization. Collaboratively, it

confirms that the outcome of this project galvanized the three communities in working together to provide a vital service.

The Island Communities

There is a group of Maine EMS professionals who are brainstorming the feasibility of creating a marine ambulance service. The goal is to establish a consistent, reliable emergency medical transport system dedicated to serving the offshore island communities. The scope of the project is based upon the system of "water ambulances" used in the country of Norway.

Fixed Facilities

With a number of communities bolstering their public safety service reliability by hiring personnel to provide around the clock coverage, it is becoming apparent that there may be facility deficiencies that need to be addressed. As an example, the town of Thomaston has taken the initial steps towards replacing its current fire station that has been deemed outmoded and lacks sufficient space, including living quarters for around the clock staffing. The town has identified a plot of land and has recently received an architectural and operational report identifying the needs of the fire and rescue department. The estimated cost for constructing a new turnkey building was estimated $8 million in 2024.

Currently, it appears the only fire and EMS facility upgrade is the construction of the new four-bay West Rockport Fire Station. A full assessment of the county's public safety facilities may be warranted to determine what shortfalls and potential deficiencies each community is faced with.

NorthStar Emergency Medical Service

NorthStar, a Farmington, Maine based ambulance service was brought into the MaineHealth network to serve both Waldo County General Hospital and Pen Bay Medical Center as their primary inter-facility transfer service. The hospitals needed continuity and assurance that they had readily available transport service so that patients did not have to wait to get the higher-level medical attention they required.

At this time, it is believed that the NorthStar ambulances that are assigned to the mid-coast are not considered part of the region's E-911 medical emergency response system. NorthStar is operating out of a 4,000 square-foot leased facility located on Route #1 in Northport.

The following accounts provide a general idea of what other areas in New England have pursued in attempting to enhance public safety service delivery systems.

Affordable Housing

Maine School Administrative District (SAD) #28 is pursuing an innovative opportunity to convert a district-owned school building into affordable apartments for schoolteachers to reside. The plan is adapt the three-story wood frame building located in downtown Camden into eight to ten individual apartments. The intent is to incentivize prospective teachers to relocate to the area, settle within the community they teach, and not have to agonize over the conundrum of finding somewhere to live at the onset of their career.

Could such a program be the catalyst in addressing the shortfall that fire and EMS departments are experiencing in staffing levels? Can we attract and retain public safety personnel, particularly within those departments that rely upon volunteer and on-call members through the enticement of low-rate rental programs? In return, those chosen for inclusion would be required to meet certain expectations regarding credentialing and emergency response.

Conn. officials promote ‘First Responders’ Village’ as housing, recruitment solution

The Lyme Affordable Housing Commission unveiled a plan to buy property near the firehouse to create housing for volunteer firefighters

(From "The Day" newspaper - New London, CT. March 21, 2024)

Treat volunteer and on-call fire fighters and EMTs' as part-time employees

Reclassifying emergency service personnel as part-time employees who would earn competitive wages and perhaps certain employee benefits may entice current personnel and potential newcomers to be more engaged in their department's deployment needs. Paying good wages for time spent responding to incidents, attending training programs, and undertaking ancillary duties may bolster the rate of activity within the department. Although implementing enhanced remuneration programs will require more funds and oversight, it may enhance a department's stability and resiliency.

KNOX COUNTY EMS

Should Knox County embark upon delivering emergency medical services with a single agency? If not at the county level, then could a corporation be formed among the group of communities to achieve a regional system?

At this juncture, this is not a suggestion but perhaps a topic that is worthy of further discussion. There has been much movement with the delivery of EMS across Maine and the country, with many communities having to enlist the paid personnel model to ensure their municipality has adequate and reliable ambulance service.

Here in Knox County, one part of a four-town consortium, Rockport, which has contracted with a for-profit EMS provider for more than a decade, is creating its own stand-alone municipal ambulance service that is expected to be up and running in late 2024. Camden is also contemplating the eventual establishment of its own town-run emergency ambulance transport services within their fire departments. These two scenarios would effectively cancel their relationship with the contract service. At this time, it is unclear how the towns of Hope and Lincolnville would address their EMS needs, and whether or not the current EMS contractor would continue providing that service should Camden strike out on its own path similar to the enterprise that is unfolding in Rockport.

The City of Rockland, and the towns of St George, South Thomaston, Thomaston, Cushing, Warren, and Union each have their own ambulance services. Can or should these services stay autonomous?

The Anatomy of a Newly Created County Based Ambulance Service

Cheshire County, located in southwestern New Hampshire has created a county-based emergent and non-emergent ambulance department.

(NOTE: The following excerpt is from the Cheshire County New Hampshire website regarding the creation of the Cheshire County EMS.)

The Cheshire EMS started operations on November 15th, 2022. Currently, we are working with Cheshire Medical Center on Inter Facility Transfers for critical patients, hoping to take on or support 911 EMS calls in our communities.

For several years, the County has been involved in discussions regarding the vulnerable nature of the emergency medical services structure. Without exception, every community has been concerned about resource and manpower shortages. After years of debate and discussion, the County became the sole architect of a solution: The County would establish a new county department that provided emergency medical services using funds provided by the American Rescue Plan Act (ARPA). This new county department will include newly acquired property at 53 Monadnock Highway in Swanzey

and the construction of a new building as well as the purchase of 7 ambulances, a squad car and a wheelchair van. The department is expected to hire 30-35 personnel and will have an operating budget of $3.5 million that will be paid for by the users and not by the general property taxpayer.

Conclusion:

Cheshire EMS currently provides primary 9-1-1 ambulance service (basic life support and advanced life support) to Harrisville, Marlborough, Stoddard, Gilsum, Richmond, Westmoreland, and Swanzey with ambulances based in Swanzey and Westmoreland. Cheshire EMS provides backup ambulance service and paramedic intercept service to Troy, Fitzwilliam, Winchester, Marlow, and Alstead along with paramedic intercept service to Walpole. This week, Cheshire Medical Center initiated a part-time paramedic intercept service that further strengthens the countywide EMS system. Through our public-private partnership with Great Brook Ambulance and SMARTRide, additional resources are available for 9-1-1 response and emergency and non-emergency inter-facility patient transfers. To say that the establishment of Cheshire EMS has weakened the County's EMS system is ludicrous.

It has and will always be the County's position and hope that it can find common ground, work together, correct any misconceptions, and most importantly be a strong partner with the City of Keene. Again, if Keene Fire Department calls Cheshire EMS tomorrow and asks for help responding to a call, Cheshire EMS will do whatever it can to meet that need.

In closing, just to emphasize some key points concerning EMS services in Cheshire County, it was not the County's original intent to start its own service. The County's involvement began when it was asked to step in and help with equipment for DiLuzio Ambulance and then to purchase the entire business. County officials looked to Rescue Inc. Stewart's, and more to fill the region's need, but no one would take on the DiLuzio Ambulance business. So, the County moved forward not knowing much about DiLuzio's financial situation. The County and DiLuzio agreed upon a MOU, but an asset purchase agreement was never signed. Both documents remained unsigned by them. The County's due diligence search of publicly available records significant liens against DiLuzio Ambulance assets, including IRS liens, which prevented the purchase of DiLuzio Ambulance's assets. The County was approached by a town that was contracted with the City of Keene and made the uncomfortable and controversial decision to accept their request to provide 9-1-1 ambulance service. It was never the County's intent to cause harm to the City, but the County supports the right of any town to choose its ambulance service. County officials were not made aware of the negotiations between the City of Keene, DiLuzio, and Rescue Inc., which County officials believe were intended to thwart the establishment of Cheshire EMS. County officials welcome the opportunity to work with the City of Keene to address any concerns so we may support one another and the community. On multiple times, County officials have asked representatives of the fire union to meet to answer any questions they may have. It is the County's hope that in the near future, the fire union will recognize that Cheshire EMS

does not pose a threat to their jobs or to the important service that the Keene Fire Department is providing to the region. It is the County's vision that all public safety agencies, private providers, and the hospital community will collaborate to establish an EMS system in Cheshire County that seamlessly provides the highest quality of patient care in an equitable manner to all of our citizens.

County government as we have known it in the past is evolving due to multiple factors in our rural community. More and more the County is being called on to assume needed roles in the community, whether that be towns needing law enforcement, regional prosecution, Cheshire Community Power, school districts needing support around truancy, and now EMS services. County officials approach every situation and challenge thoughtfully and pragmatically. Policy decisions are always made in public meetings and on the public record with opportunity for public input into consideration before making a decision. The County has and will always welcome public input on any matter. The County's goal is to ensure that our communities are safe, and prosper, but also to work within the fiscal reality we are faced with in our corner of the state. In 2023 taxes to be raised from the County saw NO increase from 2022. County officials understand the stress towns are under in Cheshire County and appreciate those towns giving us the chance to explain ourselves and address misconceptions or untruths that have been presented.

APENDIX "A"

York County Maine

The following is the excerpted job description for the York County Maine Fire Administrator. Under the authority of the York County Emergency Management Agency, the County created this position approximately four years ago, and it is believed to be the first of its kind in Maine. The impetus for creating the position at the county level was to provide a clearinghouse where fire and EMS departments across the region could seek assistance in addressing myriad circumstances that can impact the organizations. Regulatory compliance, multi-agency coordination, grant funding, training opportunities, administrative guidance, problem solving, human resource coaching, planning and implementation, are but some of the areas the chief administrator is charged with providing.

In the 2015 Knox County Fire Service Assessment report, one suggestion was for Knox County to consider creating a fire administrator or coordinator position (See page 17 of that report).

Although Knox County has not pursued the creation of a fire administrator position, key officials have been in contact with the EMA office in Alfred, Maine to learn more about the position. To that end, it may behoove the county fire chiefs in conjunction with the Knox County Commissioners as well as the Knox County EMA office to explore the benefits of creating a fire administrator position.

The following passage is the job description for the York County administrator:

York County Chief Fire Administrator Job Description

ESSENTIAL DUTIES AND RESPONSIBILITIES

Including the following. Other duties may be assigned.

- Coordinates Fire and EMS operations training as it relates to emergency management programs.
- Recommends and coordinates ICS training courses for Fire and EMS operations including ICS programs that interface with emergency management programs.
- May supervise and/or coordinate activities of volunteer teams in the Operational or Response areas for first responders.
- Advises on and coordinates the establishment of policies and procedures for Fire and EMS across the county as it interfaces with emergency management.
- Plans and Implements Fire and EMS programs at the County level to better coordinate policies and goals set forth in the various Towns' Codes, Ordinances, and the State Fire Code.
- Prepares required EMA documentation and correspondence for training, incident reports, grant funding, etc.

- Confers with federal, state and local officials concerning emergency management and fire protection; regulates and secures and maintains technical and financial assistance through state and federal programs; coordinates mutual aid agreements and procedures with public and private agencies.
- Coordinates EMA support activities in response to alarms in local communities assisting Fire and EMS.
- Prepares and submits monthly reports to the County EMA Director and the County Fire Chiefs association regarding support activities to the Local Fire Departments within the County.
- Evaluates the need for and recommends the specific EMA Fire Service interface training needed by all York County Towns.
- Represents EMA at Fire and EMS coordination meetings, seminars, and other functions.
- Coordinates and participates with:

    - Incident Management Team
    - Incident Management Assistance Team
    - Tactical Dispatch/Response

- Coordinator of group purchases including medical supplies for York County Fire and EMS departments. Coordination of purchases with the intent of using County bulk purchases to garner savings for local communities.
- Liaison to Region 1 EMS.
- Coordinator/Scheduler of York County:

    - Fire, specialty classes such as Hazmat, Officer Development, etc.
    - EMS: Instructor CEU classes, EMS CEU classes, etc.
    - Emergency Management Training, Incident Command System courses, lessons learned, damage survey exercises, etc.

- Special Projects
- Communications/Coordination with all towns.
- PERIPHERAL DUTIES

    - Attends conferences and meetings to keep abreast of current trends in the field.
    - Represents York County EMA at all Fire and EMS meetings in a variety of local, county, state meetings.

Harpswell, Maine

In yet another example of a fire administrator, the town of Harpswell, Maine created a municipal position to assist with the operation and management of the town's three separate volunteer fire and rescue associations, which are not under the jurisdiction of town government. The goal of the administrator's position is to preserve the institution of the three autonomous fire associations, yet provide guidance in the mission and responsibilities of the emergency services.

Town of Harpswell Fire Administrator Job Description

GENERAL SUMMARY:

The Fire Administrator shall provide management, staffing, and support to maintain the Town of Harpswell Municipal Firefighter (FF) coverage in support of town-wide firefighting and EMS coverage during designated hours. The Fire Administrator shall be responsible for recruiting, making recommendations for hiring, and scheduling of town staff to cover planned shifts including training. The Fire Administrator shall also be responsible for coordinating and providing town support for the three Volunteer Fire Associations; for town record-keeping, reporting and standards compliance; and for working as a fire fighter providing town-wide coverage during designated shifts.

This is planned as a full time position with benefits and it is normally expected that this position will cover a minimum of two (2) 12-hour municipal firefighter shifts per week, and other gaps as needed. When covering as a municipal firefighter, the Fire Administrator shall work at a station but otherwise may perform job responsibilities from the town office.

The Fire Administrator is expected to meet quarterly with the Town Administration, Fire Chiefs and a member of the Select Board.

ESSENTIAL JOB FUNCTIONS:

- Acts as a firefighter and responds to fire and emergency calls during assigned shifts.
- Coordinates and manages staffing for town provided firefighters under the direction of the designated department head. This will normally include the first line of recruiting, interviewing and qualifications assessment of potential hires.
- Acts as the main point of contact with respect to town provided fire and rescue services.
- Implements Maine State Bureau of Labor standards requirements for municipal firefighters, including administration of the Respiratory Protection Plan, Exposure Control Plan, Infection Control Policy, Hazard Communications Plan, Turnout Gear Inspection, and other mandates.
- Provides and maintains the necessary documentation required to ensure that the

town and its municipal firefighters are operating within the established guidelines of various State and Federal regulatory agencies.

- Coordinates and manages town fire activity purchasing in accordance with town policy, including recommending budget items, obtaining prices, approving invoices, and ensuring compliance with budget. Assists in the preparation of budgets and estimates for town fire equipment. Maintains town equipment and items, and issues firefighter personal protective equipment (PPE), radios, etc. and performs SCBA and respirator mask fit-testing. Ensures programming and manages town radio equipment as required. Arranges for the repair of equipment items and maintains equipment maintenance records. Maintains necessary inventory records.
- Assists the volunteer companies in efforts to recruit new members and in the initial intake process. Provides, as needed, new member orientation, new hire paperwork, and assists with training. Assists in training volunteer firefighter members on annual mandatory training topics.
- Provides necessary training to town employees and town volunteers including driving, equipment and BLS requirements.
- Maintains medical and training records for municipal firefighters and notifies applicable staff members and supervisors of unmet training requirements or medical evaluations. Prepares and files firefighter injury reports and worker's compensation claims.
- Assists as needed in general maintenance work required for the upkeep of fire facilities and equipment.
- Acts as Town Fire Warden.
- May be appointed by the Board of Selectmen as the Town's Emergency Management Agent and Health Officer.
- Performs any further related duties assigned by the Department Head and/or Town Selectmen.

SPECIAL REQUIREMENTS

The duties listed above are intended only as illustrations of the various types of work that may be performed. The omission of specific statements of duties does not exclude them from the position if the work is similar or related to the position.

Hancock County, Maine

In another scenario, seven fire departments in central Hancock County filed an application with the U. S. Government's Federal Emergency Management Agency (FEMA) for a grant provided by the Staffing for Adequate Fire and Emergency Response (SAFER) program. The participants were successful in landing a $1,239,537 grant that is intended to bolster the number of volunteer fire and EMS personnel in the those seven member communities. The goal and objectives of the program is to hire someone as the Volunteer Recruitment and Retention Administrator (VRRC) for a four-year period, add 80 new fire fighters to the roster of the collective fire departments, and to retain those who are already members of a department. The funds allocated to this endeavor will cover the cost of the administrator's salary, procurement of necessary personal protection equipment, medical surveillance of new hires, delivery of requisite training, career development for incumbent members, and other related expenses.

Volunteer Recruitment and Retention Coordinator (VRRC) - Job Description

(Note: Though this position is for employment with the City of Ellsworth, the Ellsworth Fire Department, the position is temporary, part-time (32 hours), is a federally funded grant position (4 years), and may be subject to further requirements due to federal funding.)

Organizational Summary:

The member departments of Dedham, Ellsworth, Hancock, Lamoine, Mariaville, Orland and Trenton came together in 2021 to develop a mission to represent, coordinate and support the member departments' fire, rescue, EMS volunteers in central Hancock County, Maine. The member departments protect approximately 19,000 citizens in the region with predominantly all volunteer or combination departments.

Position Summary:

The Volunteer Recruitment and Retention Coordinator (VRRC) develops, implements, leads and manages, plans projects and programs designed to raise the visibility, as well as to increase the number of volunteers for the seven local fire and rescue departments in our combination and mostly volunteer system. The recruiter shall work to raise visibility among the public, students, businesses, community organizations, funders and other stakeholders.

The expected outcomes of activities executed by the VRRC will be to recruit volunteers for membership and training as firefighters and emergency medical services providers throughout the seven affiliated departments. This position reports to the Fire Chief for the City of Ellsworth and works directly with the Recruitment & Retention Committee (R&R).

Basic Position Responsibilities:

- Recruit volunteers to meet the needs of the seven affiliated combination and volunteer fire and rescue departments; Identify potential sources of volunteers and implement strategies to reach all communities;
- Actively schedule and conduct recruitment presentations in schools, and community groups;
- Continually update and enhance recruitment presentations and materials; Update and enhance social media channels to serve as a resource for program participants and to communicate with the public for review and approval;
- Draft and disseminate press releases and public service announcements to support recruitment efforts and visibility;
- Help to design and produce events that will elevate the volunteers' profile in the community;
- Conduct regular follow-ups with applicants and members;
- Recruit, train, and manage student and community interns at recruiting station;
- Prepare Semi-Annual SAFER reports, statistics, and data for inclusion in federally required reports;
- Maintain records and prepare monthly reports to the R & R Committee;
- Attend monthly member department meetings and R&R committee meetings as needed;
- Schedule, prepare, and staff school career events;
- May be required to participate in fire ground activities to included fire suppression or rescue;
- Other duties as assigned.

Concord, New Hampshire Region

Capital Area Mutual Fire Aid Compact

The Capital Area Mutual Fire Aid Compact is a group of 24 city and towns in central New Hampshire that covers an area of 877 square miles and was established in 1976.

Purpose of the Compact:

The member departments do hereby voluntarily associate themselves in this Compact for the purpose of rendering mutual aid assistance in time of need; to provide for the betterment of the several Departments, both individually and collectively, by a mutual exchange of information and service and specifically to provide better protection for the citizens of the several towns whose lives and property we are pledged to protect by mutual effort. Such association shall in no way prohibit any member from rendering assistance to a non-member department. (From the Compact's By-Laws, Revised 2022)

Articles of Association:

The object for which this district fire mutual aid system is established is to "coordinate" the services of all fire departments belonging to it so as to provide better and more efficient cooperation in the protection of life and property against fire within the area; to establish an overall plan or plans for such coordination; to acquire and operate property and equipment, including a dispatch center, and a communications service within the limits of available funds, to extend the advantages of group purchasing and benefits to departments in the system, to borrow money for the purpose of the system and to pledge the property of the system as security for the same; to provide and operate training programs for firefighting and other, to cooperate with other state agencies and with civil defense authorities, and to do any and all other manner of things not prohibited by law. (February 1976)

The Compact is staffed by a full time chief coordinator, and has recently expanded staffing with a newly created deputy coordinator.

PARTNERSHIP

The captioned logo embossed on the door of the Town of Union's ambulance is testament to the relationship that has been fostered between Union, Appleton and Washington. The municipality of Union not only provides EMS services to its residents, it is also under contract to provide ambulance service to the two neighboring towns. A committee comprised of appointed residents of each town provides oversight of the ambulance service.

Modified Informed Community Self Determination (ICSD) EMS Evaluation in and for the Towns of Camden, Hope, Lincolnville, and Rockport and the Pen Bay Medical Center - Final Report

I. Executive Summary

The towns of Camden, Hope, Lincolnville and Rockport have received 9-1-1 emergency medical services (EMS) response coverage from North East Mobile Health Services (NEMHS – a private company based in Scarborough, Maine) since 2013. For some 77 years before, that service was provided by the Camden First Aid Association (CFAA), a non-profit ambulance agency overseen by a community board. Pen Bay Medical Center (PBMC) had been served by NEMHS prior to 2013 to transport its patients requiring certain emergency services to other facilities (called "inter-facility transport" or IFT) for that care. In mid-2020 and anticipating the NEMHS contract conclusion on June 30, 2021, PBMC and the towns of Camden and Rockport sought advice on weighing options for future EMS coverage. This report summarizes the process that ensued.

In the most recent years of NEMHS' service to the area, increasing discussion among local public safety, government and hospital officials about satisfaction with elements of that service has occurred. Presentations of potential fire-based EMS alternatives for 9-1-1 response have been entertained, and PBMC continues its use of NEMHS but without a current contract. A Maine-based EMS system professional was asked to lead this project utilizing aspects of the EMS "informed community self-determination" (ICSD) approach he had developed with other national experts. He and two colleagues served as Project staff to conduct an evaluation of the current service within an overall process to determine what options, in addition to a status quo option (in other words, no change from the current service) would best serve the area, and who would make the decision in choosing among options.

An initial Steering Group was selected by the towns of Camden and Rockport and PBMC to guide the Project and to review and approve its modified ICSD process in summer, 2020. In subsequent meetings, the Steering Group invited and added representatives selected by Hope and Lincolnville and helped to translate findings into recommendations for the Project. An initial example of this was a recommendation based on Project staff input to not proceed with a request for proposals (RFP) for EMS service in the area as an option. Staff research indicated that EMS workforce constraints in Maine EMS agencies, uncertainty created by the pandemic and other issues made that a likely unpromising route.

Through Fall and Winter as the evaluation component continued, the Steering Group met frequently (weekly at times), and reviewed staff research and findings, developing what evolved into ten potential options. In early 2021, it became evident to the Steering Group that issues identified in the evaluation precluded consideration of a status quo option because at least some contractual changes with NEMHS would be needed if it continued service. The Steering Group considered other options that called for starting a new fire-based service or a joint NEMHS/fire service venture. They felt that these had

possibilities but not in the timeframe beginning July 1, and especially in the uncertainty of the operational and financial environment created for EMS and PBMC by the pandemic.

Ultimately, the Steering Group consulted with the select boards as the decision-making entities at this level, to select an option to present to taxpayers in the referenda that COVID conditions dictated would be used in place of town meetings. The town decision-makers agreed with an option that called for continuing NEMHS for an additional one-year contract with an option for a second year. The contract would contain a number of new provisions that addressed issues identified in the evaluation and included operational and medical leadership staffing and communications, accountability and reporting, and participation in accreditation and other processes that better assure performance oversight and improvement. NEMHS and PBMC renewed communication about interfacility transport and other joint issues identified in the evaluation.

This option also recommended that a fire-based first response unit be formed in the four towns in an initiative with one town serving as the Maine EMS licensee and administrator, the same or another town providing the EMS chief, but all four towns benefitting and soliciting members. The four towns would contribute to a small fund to cover insurance, licensing and other administrative costs, but would individually budget to equip and pay for first responders answering calls in their towns.

Finally, the option recommended that the towns sponsor an EMS regionalization planning project in 2021-2022, guided by an experienced municipal planner, to evaluate the options for a new form of service to address EMS and possibly fire service needs. Other area towns would be invited to participate. An estimate of cost was received from a planner approved by the Steering Group.

The financial impact of this option for the towns would be:

- A .6% increase for the NEMHS contract for 2021-22 based on the New England Consumer Price Index,
- A population apportioned split of $20,000 for the regional planning initiative,
- A population apportioned split of $1,200 for the first responder unit administrative costs.

Table 1

Town	2010 Population	2010 Population %	2019-20 NEMHS Contract	2020-21 NEMHS Contract	2021-22 NEMHS Contract	2021-22 Regionalization Plan Initiative	2021-22 1st Responder Admin. Costs
Camden	4,851	41%	$122,066	$123,202	$123,941	$8,200	$492
Rockport	3,330	28%	$83,810	$84,138	$84,643	$5,600	$336
Lincolnville	2,164	18%	$54,463	$54,089	$54,413	$3,600	$216
Hope	1,536	13%	$38,658	$39,064	$39,298	$2,600	$156
Total	11,880	100%	$298,997	$300,492	$302,295	$20,000	$1,200

II. Background and Project Overview

Community-based emergency medical services (EMS) find themselves somewhere between the all-volunteer, first-aid providing, donation-supported rescue service which first came to be and the all-paid, paramedic, professional health care operation of a hospital, fire or other municipal department, or private company now common in most cities.

The public's expectation of the EMS professionals who arrive at their door is high. In 1973, the public expected no more than a lights and siren, "horizontal taxi" ride to the hospital frequently provided by community volunteers. By 1983, the media-influenced public didn't know whether to expect just the fast ride to the hospital or life-saving care in the back of the ambulance. But by 1993, a Maine EMS study showed that almost 90% of Maine's citizens expected paramedics (the highest level of EMS capabilities) to arrive at their doorstep for their heart attack. With media influence, there is no reason to believe they expect anything different today regardless of what is actually available.

Most emergency medical services are moving from the volunteer/basic care end of the spectrum to some point closer to the paramedic, all-paid end in urban and suburban centers. Rural EMS agencies face challenges in doing so, because of intertwined transport volume, financial and workforce availability issues exacerbated by the declining availability of other health care resources in their communities. The need to transport patients to more distant urban facilities to which higher levels of health care have gravitated takes ambulances away from availability for 9-1-1 response.

The Camden-Rockport-Hope-Lincolnville area was served for 77 years by the Camden First Aid Association until financial issues led to a significant increase of subsidy request to the four towns in 2013. Subsequently, the towns contracted with North East Mobile Health Services ("NEMHS") for 9-1-1 service. Additionally, NEMHS has already been and continued to be a principal transporting agency for patients transported out of Pen Bay Medical Center (PBMC) in Rockport.

NEMHS' initial contracts with the towns have been renewed to date with all four town agreements aligned for a common sunset date of July 1, 2021. There have, however, been increasing discussions among principals in the towns and the hospital about NEMHS's ability to meet the demands of 9-1-1 response and the interfacility transport needs of PBMC. These discussions resulted in a request, with approval of the town and hospital parties involved, to Kevin McGinnis to utilize a modification of an EMS evaluation process called Informed Community Self-Determination (ICSD) to study the situation and provide options for future action.

Finally, for the sake of transparency, the principal advisor in this process, Mr. McGinnis, is a past chief/CEO of NEMHS from 2011 to 2014 and advisor to NEMHS from 2014 to 2016. The hospital and Camden and Rockport town principals recognize this past affiliation and have requested this proposal regardless of that fact. In turn, Mr. McGinnis partnered with Michael Senecal, an experienced EMS director in western Maine, for the

evaluative components regarding NEMHS to assure objectivity. Enhancing this expert objectivity, the project also utilized Dr. Richard Narad, a California university health services systems faculty member and expert on EMS systems evaluation, comparison and contracting. The Project staff advisors and their backgrounds are in Appendix E.

III. Purpose and Format of the Evaluation

Kevin McGinnis and his associates, Mr. Senecal and Dr. Narad, (the Project Staff advisors), conducted an independent, objective evaluation of emergency medical services capabilities and needs in and for the towns of Camden and Rockport and for PBMC, and expanded to include Hope and Lincolnville. This evaluation produced a description of the current operation with recommendations for improved response and patient care as were indicated, and options for alternative delivery models. The advisors worked with the towns and PBMC through a Steering Group selected by them, and a local EMS expert and facilitator, to define the process by which these options will be considered and by which decision-makers. The advisors then assisted the towns and PBMC in informing the decision-makers about the process and options that they will consider. The scope of the contract spanned from evaluation to selection of an option, and was extended to include contract discussions with NEMHS. Subsequent implementation of the selected option was, otherwise, beyond that scope.

The advisors drew upon the ICSD evaluation process and template as they deemed relevant to this project. They worked with Tom Judge who was the local EMS expert/facilitator of the project staff and initial contact and project organizer with town and PBMC principals. The evaluation and recommendations components included, as the project evolved under the Steering Group's direction and as represented in this final report:

North East Mobile Health Services in the Camden-Rockport Area
This is an historical and quantitative picture of the services now provided. It provides decision-makers with a foundation of critical information from call and interfacility transport response profiles (call volumes, types, times, level of care and other response characteristics as available) to current staffing methods.

North East's Other Capabilities and Performance
This is a qualitative look at the functional effectiveness of the service. It is organized to assess critical components of an ambulance service such as governance, general operations, patient care, facilities and equipment, staffing, training, safety, budgeting/finance (as information is made available), and community relations/services. It will gather and analyze issues identified by stakeholders and/or observed by the advisors as a part of the foundation upon which to develop operational options for decision-makers to consider.

Camden-Rockport-PBMC: Options to Meet Community Needs for an Agile, Responsive EMS Resource

This section takes the NEMHS organization in the Camden area and Maine in general, as profiled in the previous two sections, and analyzes its strengths and weaknesses, as well as its opportunities and challenges. It then offers recommendations to make NEMHS, with consideration of possible fire department first response partners, a reasonable model for continuing its service to the area. Finally, other operational options and their relative cost implications will be considered by the Steering Group in an agreed-upon ICSD format.

IV. ICSD and the Camden-Rockport-PBMC Project

Rural and Frontier EMS Agenda for the Future, a book published by the National Rural Health Association in 2004, proposed the Informed Community Self-Determination (ICSD) model of community-engaged planning. It was designed to help communities with jeopardized EMS agencies redesign EMS services that fit with local tax-base and other resources and capacities and that reflect community preferences. Most simply stated, ICSD is designed to credibly inform taxpayers and/or their elected representatives regarding the type and level of EMS they currently have, reveal flaws or limitations to address, explain alternative levels of basic or advanced care and types of response that could be available, approximate the cost of adopting those alternatives, and facilitate a taxpayer decision to fund their current coverage or adopt a new plan. Specifically, ICSD provides a process in which:

- An outside expert or entity conducts an objective evaluation of the EMS service;
- The evaluator reports openly on the level of care, method/speed/availability of response and any issues which affect those factors;
- The evaluator reports any deficiencies which jeopardize service performance in order that they can be addressed immediately or entered into the ICSD discussion as indicated;
- Based on accepted national practices and state EMS law and regulations, options are presented and their implementation and financial impacts explained in terms of costs, projected revenues, other sources of funding, and the effects of changes on local, tax-based subsidies; and
- The community holds a meeting(s) of taxpayers and/or their representative decision-makers to select a level and type of service it desires and establish the level of funding needed to implement and sustain it.

In short, the ICSD process is designed for isolated rural communities with EMS operations in jeopardy and involves informing taxpayers or their authorized representatives about the type and performance of their EMS agency, what options for change they might consider, and at what cost to them. Then they are guided through a process to decide among the options.

The greater Camden EMS service area is not strictly the type intended for application of ICSD. It is more urban, wealthier, and includes multiple towns, a health-system affiliated

hospital with interfacility transport needs and, therefore, multiple sets of decision-makers. However, ICSD principles have been successfully applied in similarly more complex settings as well, addressing other EMS-related issues in Maine.

In this case, an evaluation of NEMHS' type and level of performance in meeting 9-1-1 and interfacility obligations was requested. Based on this evaluation, the current and alternative operational models addressing both 9-1-1 and interfacility needs would be described as options.

In the proposal for this process, it was specified that the project staff would "Meet with town, PBMC and North East principals to agree on the process to be followed in the project and execute the "Emergency Medical Services (EMS) Informed Community Self-Determination Program Agreement" (Appendix B of the ICSD template: https://nasemso.org/wp-content/uploads/2020-Template-for-Informed-Community-Self-Determination-v-6.1.pdf)". This would include a definition of the decision-making process and decision-makers to be involved. Because of the Project contracts established with Camden, Rockport, PBMC, and the Project staff, and the voluntary participation of NEMHS and two of the towns, the consensus on process developed throughout the Project by the Steering Group, sufficed to meet this ICSD agreement procedure. This was but one of the ways Project staff adapted the ICSD process to facilitate the needs of the stakeholders as allowed by the contracts in force.

The ICSD process initially utilizes a core group of key stakeholders to guide and help the staff through the evaluation and option development processes. In this Project, it included representatives of the Project clients, the towns of Camden and Rockport, and PBMC. As previously mentioned, it also included a volunteer facilitator who is a local resident and respected national EMS system expert and was a part of the original discussions among local town government, public safety and PBMC members about EMS coverage. He had been asked to help formalize this process by stakeholders and secured the consulting staff for the Project. After initial organizing meetings in the summer of 2020, the core group invited the Town of Hope and the Town of Lincolnville to be represented on the Steering Group as key stakeholders which included:

- **EMS Project Steering Group**
  - Tom Judge. Volunteer facilitator. Executive Director, LifeFlight of Maine.
  - Audra Caler-Bell. Camden Town Manager.
  - William Post. Rockport Town Manager.
  - Chris Michalakes, MD. Emergency Physician. PBMC.
  - Nancy Jackson, RN. Director of Emergency Services. PBMC.
  - Stephen Skinner, MD. Emergency Physician. PBMC
  - Sarah Ann Smith. Chair, Hope Select Board.
  - Thom Ingraham. Member, Hope Select Board.
  - David Kinney, Lincolnville Town Administrator.

The Project proposal and contracts were developed and completed through July and August, 2020 by the Project staff leader, the Towns of Camden and Rockport, and PBMC. The Project staff was assembled and began work in September.

The core of the evaluation included a review of Maine EMS, NEMHS, KRCC (Knox Regional Communications Center) and other data relevant to the functioning of EMS in the project area. This was accomplished by the three Project Staff advisors. An evaluation of NEMHS itself, including all relevant inspections of facilities, equipment, records, operating procedural and other materials, and interviews with leadership, staff, and KRCC officials was conducted by Mr. Senecal. Evaluation of contract materials and review of findings and recommendations as they emerged was done by Dr. Narad and Mr. Senecal, when presented or developed by Mr. McGinnis. The remaining interviews were conducted by Mr. McGinnis with some assistance by Mr. Senecal. Interviewees were those recommended by the Steering Group or on their own action by the Project staff (virtually all of these were accomplished with only a few who did not respond to multiple phone calls and/or emails; only two resulted from e-mail correspondence and not a direct interview). Interviewees were assured of anonymity in their participation and comments, but resulted in 43 interview sessions which included all or a sampling of the following (where "town(s) is cited it means the four Project towns unless otherwise specified):

- Town managers/administrators and other officials
- Town select board chairs and members, and past EMS Performance Review Committee members
- Town and neighboring fire department chiefs, other officials and a sampling of members
- Town and county law enforcement officials
- Knox Regional Communications Center staff
- Town residents and business operators
- PBMC leadership and staff
- Staff involved in emergency department operation in Waldo County General and Miles Memorial Hospitals
- Maine EMS and Atlantic Partners EMS (Mid-Coast EMS Council) officials
- NEMHS leadership and a sampling of Rockport-based EMTs/Paramedics

The first option to be considered was whether the towns and hospital could entertain a request for proposal (RFP) process, given a 2012-13 process for EMS in the area that was successfully concluded. The area has approximately 1,500 9-1-1 calls and 1,000 interfacility transports, making it a reasonable prospect for at least an in-state service to initiate an operation. Staff research revealed little interest from likely respondents to such an RFP given the EMS workforce fragility in Maine and regionally, and the operational and financial uncertainties created by the pandemic. The fluctuations in call volume and staffing needs among potential respondents and the uncertain future of the pandemic and its effects were specifically cited. The Steering Group was also concerned that an RFP might prematurely preclude, with long-term consequences, the opportunity for growth of a community-based service or a locally sponsored, regional service in the

future. The Steering Group agreed, then, not to attempt an RFP for EMS service in the area as an option.

The Project was originally planned to conclude in December, 2020. Since the process would not end with an RFP process, and the ICSD process is intended to match the timeframe for town and hospital decision-making which could extend through town meetings in June (or referenda if town meetings can't be held under pandemic precautions that may then exist), it was agreed during the fall Steering Group meetings that the Project would extend until its members' needs were met. This would be when an option, or options, was selected by the Steering Group and the towns and PBMC agreed that no further Project staff ICSD support would be required. There would be no additional cost for extending these services.

The Steering Group set a regular weekly meeting schedule through the fall and winter and met on most of those occasions for Project updates and to develop and select operational options to be considered. Ten options evolved from Project staff consideration of response data and issues revealed during the evaluation process and especially the interview component. Also, NEMHS and fire service leadership were solicited for ideas for further operational options and these were received and added to the mix. They were assured that details of their proposals would not be made public without permission. There was no need to do this as portions of their proposals were integrated into options anonymously as they evolved during Steering Group consideration.

As described below, one multi-part option emerged as clearly favored by the Steering Group while aspects of three others were recommended for further study as a part of the selected option. An in-person meeting was held for Project staff and a Steering Group member to explain the process, options, and potentially selected option to the four town fire chiefs. Project staff conferred with NEMHS leadership on the option that would likely be pursued. The PBMC Steering Group representatives conferred with leadership at the hospital throughout. Between the interview process and consultation with PBMC Steering Group members individually, the inter-facility transport priority of PBMC was addressed. There had been no specific contract in this regard since 2018, though staff of PBMC and NEMHS seemed to somewhat continue to abide by its provisions (e.g. method of requesting transports). During the ICSD process, a new Steering Team member was added by PBMC. This physician, Dr. Steve Skinner, is new to the area but is an EMS specialist who is becoming the EMS liaison for PBMC. The Project established a communication relationship between Dr. Skinner and NEMHS CEP Butch Russell with promise of discussions and a pathway to improving the leadership and operational communications issues identified by the Project. Dr. Skinner expressed that this, and other results of the Project, constituted a satisfactory result for the time being and that no further Project staff effort was required from his perspective.

Based on input from these informational meetings, details of the option were revised and budget figures further developed. Informational meetings were held on February 8 and 9 for the Lincolnville, Rockport, Hope, and Camden select boards on the Steering Group

process and option selected. A further meeting was held on March 25 for the Hope select board and budget committee.

Following these sessions, disagreements with budgeting for a first responder unit were raised. Some members felt that equipping and providing call pay for members responding in their towns would be less than the costs projected. As a result, these projected costs were taken off the proposed first response unit expense request to be apportioned to the towns. These would be managed internally by the towns in their budgeting processes. Only a $1,200 shared administrative cost would be requested to be apportioned to the towns.

Project staff researched alternative means for apportioning the EMS coverage and other shared costs of the option selected and over three weeks' meetings these were reviewed and discussed by the Steering Group, with time to review with their town colleagues. Finally, a population-based apportionment method using most recent census figures was chosen, as it had been in previous years.

V. North East Mobile Health Services in the Camden-Rockport Area

The towns of Canden, Hope, Lincolnville and Rockport have received 9-1-1 emergency medical services (EMS) response coverage from North East Mobile Health Services (NEMHS – a private company based in Scarborough, Maine) since 2013. For some 77 years before, that service was provided by the Camden First Aid Association (CFAA), a non-profit ambulance agency overseen by a community board. When financial and other difficulties evolved for CFAA around 2012, their ensuing request for an eight-fold increase in town subsidies led to a request for proposal process that attracted four candidates with NEMHS subsequently being awarded the contract.

Pen Bay Medical Center (PBMC) had been served by NEMHS prior to 2013 to transport its patients requiring certain emergency services to other facilities (called "inter-facility transport" or IFT) for that care. This relationship reflected NEMHS' pattern of serving the evolving Maine Health system service area, of which PBMC was increasingly a part, as widely as possible.

That CFAA was a community-based service gave it hometown characteristics that are appreciated in the area: local board and executive leadership, staff largely drawn from the communities served, and an informal "first response" capability created by ambulance staff listening to public safety dispatch radio traffic and assisting with calls in their home areas even when not on duty. CFAA was born out of the volunteer tradition common in EMS, and evolved into a version of a paid service also frequently the path of modernizing ambulance services in an era of declining volunteerism.

Volunteer services often depended on their appeal as a social organization to attract and retain members, while fully paid services implemented modern business and human resource development principles to succeed. CFAA's demise spoke of the pitfalls that

such services can also experience when the business acumen and leadership required of modern EMS agencies does not evolve as fast as the move from volunteer to paid service.

NEMHS is, by volume of calls, the largest of the Maine's ambulance service providers. It is based in Scarborough, has over 200 employees, and operates bases there and elsewhere in southern Maine. Its base in Rockport serves the Camden-Rockport area, and a base in Brunswick is a resource for additional ambulances and crews when Rockport's are busy. The NEMHS company is a private for-profit that shared roots in a family-owned venture that also created what is now Northern Light Medical Transport in Bangor.

Health care services such as NEMHS, that are "for-profit" entities, tend to be negatively cast to some degree, especially by others with whom they compete. In EMS, the fire service, which vies for the EMS role in the face of declining fire suppression needs, is a significant source of this tension for private services, including nonprofits. No EMS operator or sponsorship model has proven superior to another. This is fortunate, as Maine has a varied group of these among its 276 EMS first responder or ambulance agencies:

- 173 Fire Service First Responder or Ambulance Services (e.g. Rockland)
- 41 Non-Profit Community EMS Services (e.g. St. George)
- 35 Independent Municipal EMS Services
- 11 Private EMS Services (e.g. NEMHS, St. George)
- 11 Hospital-Based EMS Services
- 3 College-Based EMS Services
- 2 Tribal EMS Services

Nonetheless, the transition from CFAA to NEMHS does present a contrast from a community-based service with primarily local staff to a more generic identity with a mix of local staff and a changing set of faces from other NEMHS bases.

At the Rockport base of NEMHS, two ambulances are budgeted for staffing 24/7 at the Rockport base with a third staffed 12 hours during the daytime. A fourth vehicle is generally present as a back-up (consistent with a loose industry practice of one spare for every 3-5 ambulances in frontline use). A wheelchair van is maintained for transports not requiring an ambulance. With approximately 1,500 9-1-1 calls and 1,000 IFT calls per year, this ambulance availability seems to be more than enough to cover demand (in EMS measurement terms, this is a "Unit Hour Utilization" or UHU of 0.12 – or ambulances in use 12% of their time available for use). This is a fallacy of sorts since the Rockport base's ambulances are often on four-to-five-hour transports to Portland, and once there, may be used for local transfers on occasion. This practice, however, keeps the Rockport fleet from achieving a higher UHU enjoyed by more urban operations.

Picture 1 - NEMHS Rockport Base Garage During Project Inspection – October 25, 2020

When staffing is short and only two trucks are able to be staffed during the day, that is when Brunswick-based resources may be moved north or used for out-of-town interfacility transports. Use of these resources occurs several times a week according to NEMHS leadership and staff interviews.

NEMHS is licensed at the Advanced EMT level, with a permit to Paramedic level, by Maine EMS. This means that it must provide at least one Advanced EMT in the two-person crew responding to every 9-1-1 call. It may also substitute a Paramedic for one or more of those crew who may practice at that more advanced level. It also can provide a "Paramedic Interfacility Transport" or "PIFT" certified Paramedic on inter-facility transports when indicated.

NEMHS has, by town contract, agreed to provide a Paramedic on 9-1-1 calls that are classified by KRCC as likely to require "advanced life support" or "ALS" capabilities. These would be the skills reflected in the table below as Advanced EMT or Paramedic. Skills listed as EMT in the table are generally considered more "basic life support" or "BLS". All three levels of practitioner provide BLS to which Advanced EMT, Paramedic and PIFT Paramedics add ALS appropriate to their licensure and certifications.

Table 2

Who Can Do What When?

BASIC LIFE SUPPORT	BLS/ALS Skills	ADVANCED LIFE SUPPORT	
EMT	**Advanced EMT**	**Paramedic**	
Assists with Meds (OLMC*)	Assists with Meds	Assists with Meds	Albuterol (Breathing)
Assists with Inhaler (OLMC*)	Assists with Inhaler	Assists with Inhaler	Amiodarone (Heart)
CPR	CPR	CPR	Aspirin (Heart)
Oxygen	Oxygen	Oxygen	Atropine (Heart)
Heart Defibrillation (AED)	Heart Defibrillation (AED/Manual)	Heart Defibrillation (AED/Manual)	Calcium Gluconate (Heart)
Glucometer (Glucose Testing)	4 Lead Heart Monitor (Limited)	4 Lead Heart Monitor	Dexamethasone (Breathing)
Splinting	12 Lead Placement	12 Lead Heart Monitor	Dextrose/D10/D50 (Diabetes)
Spinal Motion Restriction	Secure Vein Access (IV)	Secure Airway (Intubation)	Diphenhydramine/Benadryl (Allergy)
Bleeding control (including	Glucometer (Glucose Testing)	Secure Vein Access (IV)	Epinephrine (Heart/Breathing)
Tourniquet and hemostatic agent)	Spinal Motion Restriction	Glucometer (Glucose Testing)	Fentanyl (Pain)
Airway Management (BVM,OPA,	Splinting	Heart Pacing	Glucagon (Diabetes)
NPA)	Laryngal Mask Airway	Heart Cardioversion	Ipatromium Bromide (Breathing)
	Blind Insertion Airway Device	Surgical Procedures (Breathing)	Levophed (Heart/BP)
	Capnography	Splinting	Lidocaine (Pain)
	EZ I/O	Spinal Motion Restriction	Ketamine (Pain)(OLMC*)
Albuterol (Patient's)(OLMC*)		Capnography	Magnesium (Heart, Breathing)
Aspirin 324 mg (Heart)	Aspirin (Heart)	EZ I/O	Metoprolol/Lopressor (Heart)
Oral Glucose (Paste)	Albuterol (Breathing)(OLMC*)	Gastric Tube	Midazolam/Versed (Seizures)
Epinephrine (Auto Injector)	Acetaminophin (Pain)(OLMC*)	Blind Insertion Airway Device	Naloxone/Narcan (Overdose)
Naloxone (Atomized)(Overdose)	Nitroglycerin SL (OLMC*)	Tourniquet and Hemostatic Agent	Nitroglycerin (Heart/Breathing)
Nitroglycerin (Patient's) (OLMC*)	Epinephrine (Auto Injector)	Chest decompression	Nitrous Oxide (Pain)
	Glucagon (Diabetes)		Ondansetron/Zofran (Nausea)
	Naloxone/Narcan	Acetaminophin (Pain)	Sodium Bicarbonate (Heart)
	Dextrose D10/D50	Activated Charcoal (Poison)	Tetracaine (Eye Pain)
	Oral Glucose (Paste)	Adenosine (Heart)	Tranexemic Acid (Bleeding)

*After Consultation with On Line Medical Control

Effective December 1, 2019 (Updated 11/3/2020) ***Courtesy of NorthStar EMS ~ www.fchn.org/NorthStar***

The staffing budget for NEMHS at the Rockport base includes an EMT and a Paramedic for each of the three staffed shifts described above (two 24-hour and one 12-hour) seven days a week. Ideally, this constitutes a staff of mostly full-time personnel with some shifts filled by part-timers or full-timers working over-time. This allows flexibility to staff with less than a Paramedic level when only BLS is required, to staff an extra truck when not otherwise scheduled, to add a PIFT Paramedic for an interfacility transport, and to address staffing challenges when staff call out or leave. Such challenges have been a problem in recent years and are discussed below.

NEMHS' specific contractual staffing agreement is to provide a Paramedic on at least 95% of calls classified as ALS. There is a financial penalty when this does not occur. Table 3 presents an NEMHS report for 2019-2020 demonstrating compliance with this contract provision in all quarters of the year.

Project staff reviewed evidence of patient satisfaction surveying done by NEMHS. This indicated satisfactory reviews when performed.

Table 3

Paramedic Response to Advanced Life Support Trips*

***Contract Requirement:** As measured quarterly, a paramedic will respond to 95% or greater of all Advanced Life Support trips

Camden					Hope					Lincolnville					Rockport					
Month	Total Calls	ALS Calls	Medic	Average	Month	Total Calls	ALS Calls	Medic	Average	Month	Total Calls	ALS Calls	Medic	Average	Month	Total Calls	ALS Calls	Medic	Average	Quarter Average
July '19	89	41	41	100.0%	July '19	7	5	5	100.0%	July '19	14	7	7	100.0%	July '19	37	13	13	100.0%	
Aug '19	70	22	22	100.0%	Aug '19	4	3	3	100.0%	Aug '19	13	7	7	100.0%	Aug '19	49	22	22	100.0%	
Sept '19	90	34	33	97.1%	Sept '19	0	0	0	-	Sept '19	7	4	4	100.0%	Sept '19	35	14	14	100.0%	
Q1	**249**	**97**	**96**	**99.0%**	**Q1**	**11**	**8**	**8**	**100.0%**	**Q1**	**34**	**18**	**18**	**100.0%**	**Q1**	**121**	**49**	**49**	**100.0%**	**99.42%**
Oct '19	92	37	37	100.0%	Oct '19	6	6	6	100.0%	Oct '19	14	7	7	100.0%	Oct '19	25	10	9	90.0%	
Nov '19	64	21	21	100.0%	Nov '19	6	3	3	100.0%	Nov '19	14	10	10	100.0%	Nov '19	40	21	21	100.0%	
Dec '19	68	24	24	100.0%	Dec '19	2	0	0		Dec '19	14	6	6	100.0%	Dec '19	31	25	25	100.0%	
Q2	**224**	**82**	**82**	**100.0%**	**Q2**	**14**	**9**	**9**	**100.0%**	**Q2**	**42**	**23**	**23**	**100.0%**	**Q2**	**96**	**56**	**55**	**98.2%**	**99.41%**
Jan '20	71	29	29	100.0%	Jan '20	8	5	5	100.0%	Jan '20	4	4	4	100.0%	Jan '20	44	23	23	100.0%	
Feb '20	68	26	25	96.2%	Feb '20	4	2	2	100.0%	Feb '20	3	1	1	100.0%	Feb '20	24	8	8	100.0%	
Mar '20	73	31	31	100.0%	Mar '20	7	4	4	100.0%	Mar '20	8	6	6	100.0%	Mar '20	26	14	14	100.0%	
Q3	**212**	**86**	**85**	**98.8%**	**Q2**	**19**	**11**	**11**	**100.0%**	**Q2**	**15**	**11**	**11**	**100.0%**	**Q2**	**94**	**45**	**45**	**100.0%**	**99.35%**
April '20	53	25	24	96.0%	April '20	5	1	1	100.0%	April '20	14	9	9	100.0%	April '20	17	9	9	100.0%	
May '20	42	16	16	100.0%	May '20	5	1	1	100.0%	May '20	20	15	15	100.0%	May '20	23	10	10	100.0%	
June '20	54	23	23	100.0%	June '20	10	5	5	100.0%	June '20	12	7	7	100.0%	June '20	18	7	7	100.0%	
Q4	**149**	**64**	**63**	**98.4%**	**Q4**	**20**	**7**	**7**	**100.0%**	**Q4**	**46**	**31**	**31**	**100.0%**	**Q4**	**58**	**26**	**26**	**100.0%**	**99.22%**
Annual	**834**	**329**	**326**	**99.1%**	**Annual**	**64**	**35**	**35**	**100.0%**	**Annual**	**137**	**83**	**83**	**100.0%**	**Annual**	**369**	**176**	**175**	**99.4%**	**99.36%**

When staffing at any EMS agency is not sufficient to respond at the time a 9-1-1 call is received, the agency staff can request (or an automatic request is triggered by agreement) to have a neighboring ambulance dispatched in a process called mutual aid. Mutual aid agreements describe the circumstances in which aid will be provided, any conditions for that aid, and how it is paid for. The towns and NEMHS participate in a somewhat generic countywide mutual aid agreements, a plan with Union enabling that ambulance to bill for NEMHS ALS assistance when needed, and a mutual aid billing arrangement with the Rockland Fire Department (RFD). Possible over-dependence on mutual aid from RFD was one of the concerns expressed in interviews and is addressed below. NEMHS pays a fee to RFD for mutual aid use and loses its normal revenue on all calls RFD handles, so there is a financial penalty built into decisions to use mutual aid. Neither NEMHS nor RFD feels that the current frequency of mutual aid use is excessive.

The information on NEMHS call performance follows a request to Maine EMS for five years of operational data. A request was also made to NEMHS for data reports that it had supplied to the towns and PBMC, based on various data including that from Maine EMS and KRCC. Maine EMS was extremely helpful in providing raw and report data for this project. Project staff advisors analyzed Maine EMS data, and found inconsistencies in the call volume and response performance data across years that we sought to employ. These appeared to have been caused by transitions in the data system used by Maine EMS as they were implemented by NEMHS and services chosen with which to compare NEMHS. These transitions were not accomplished by all services at the same time.

In addition to these idiosyncrasies, it is easy to get lost in the weeds of data reports, so Project staff present data here which demonstrate the preponderance of their impressions of response performance in the Project area and comparison towns in the most recent

years for which data was complete, reliable and understandable. They found that calendar year 2019 and NEMHS contract years 2019-20 were representative of the entirety of data reviewed. They are the most contemporary without seemingly large impact by the pandemic onset.

Table 4

Maine EMS 2019 Data:
9-1-1 Call Response Time of Incident to Time Ambulance Arrived on Scene
(In Minutes)

Response	Total	Mean Average	90th Percentile
NEMHS to Camden	903	9.4	14.0
NEMHS to Hope	70	16.4	23.0
NEMHS to Lincolnville	165	19.0	27.2
NEMHS to Rockport	423	8.8	14.7
Rockland FD to Rockland	1436	7.2	10.2
Belfast FD to Belfast	1254	11.3	16.0
Belfast FD to Northport	113	17.0	22.75
Belfast FD to Morrill	57	18.1	24.0

Table 4 shows the distribution of the 1,561 9-1-1 calls in 2019 among the four Project towns. Table 4 is representative of the 9-1-1 response time characteristics for the Project four-town response area as well as that of neighboring comparison services, RFD and Belfast Fire Department (BFD), and other comparison service data reviewed for recent years. These other comparison services included Central Lincoln County EMS (approximately 10.9 minutes overall during same period), in the Damariscotta area, Pace Ambulance (approximately 9.8 minutes overall) in the Norway area. Project staff have worked in many similar areas in the state, including NorthStar EMS throughout Franklin County and Winthrop Ambulance Service in a seven town area of Kennebec County, and were struck by no significant performance differences from those.

NEMHS response time to Camden and Rockport, the more urban centers closer to the Rockport base, ranges around nine minutes. This is consistent with RFD and BFD times for responses to their own population centers of seven to eleven minutes.

NEMHS response times to its more distant and rural areas of Hope and Lincolnville are sixteen to nineteen minutes. This compares reasonably with BFD response times (RFD not having significant volume to similar areas) of seventeen to eighteen minutes to two of its more frequent distant rural call areas.

The response times used for comparison were Maine EMS times that EMS crews recorded for time of incident to time that the ambulance arrived on scene. They should not be casually compared with "response times" used in other reports, at risk of not comparing apples to apples. This is because there are also other ways that are commonly used to measure response time performance. For instance, these include

- *"Notified to Arrival"* Time – This is the interval from when the EMS crew was informed by dispatch of the need for response to the time that EMS arrived at the scene. This includes the time it takes for the crew to prepare to respond (e.g. get out of bed at night, dress and get the ambulance started and on its way). This may be more accurate than the times recorded as "time of incident" used in the table and comparison above because it is usually recorded by a dispatcher with a universal time clock rather than an EMT or person on scene estimating the time of incident. One might expect these times to be less than the incident to arrival times reported above, because of delays between the incident occurring and the dispatcher notifying NEMHS of the incident.
- *"Travel to Scene"* Time – This is the interval from the time the crew notifies dispatch that it has left for the scene to the time of its arrival on the scene. It is expected to be less than "*Notified to Arrival"* time because it does not include time required for the crew to get in the ambulance and get it moving.

The following are these times as reported by Maine EMS for 2019 in minutes:

Table 5

NEMHS Response Town	Notified to Arrival Time	Travel to Scene Time
Camden	8.3	7.1
Hope	14.9	13.4
Lincolnville	17.6	15.9
Rockport	7.4	6.2

The primary purpose for mentioning these differences is that there has been a fair amount of discussion about response times leading up to this Project, and Project staff was aware of some apples-to-oranges comparison issues that have existed. This could be, in part, addressed by having consistent language in the NEMHS/town contracts across the board, which was not the case in 2020-2021.

While response times are a practical concern for a community and its leaders, using an EMS agency's performance on response times alone does not equate to the "life-saving" or life-improving capabilities of the modern service. Table 4 introduces another way of looking at response times which is more useful than the mean average response times now being used in Project towns as a measure and upon which to base penalties for

noncompliance by NEMHS. That method is the use of fractile response times. The last column in the table shows these for "90th percentile" responses. For Camden, by way of example, one would read the table to say that 90% of all the 9-1-1 calls in Camden represented in the table were answered in 14.0 minutes or less. This offers a more precise and manageable target for performance review and mitigation of calls exceeding a locally adopted standard (in this example, having an EMS performance review group look at all calls exceeding 14 minutes; or selecting the 95th percentile if 90th percentile still produces an unmanageably large group of calls to review). Even better is reviewing responses to calls for specific patient conditions by as small a geographic zone as possible. In this approach, times to the administration of specific treatment for those conditions is considered along with more precise response times.

Table 6 presents another example of a report made by NEMHS on a regular basis for the Project towns on response times. The original NEMHS/town contract language that governed response time was "total time from when the call is acknowledged by NEMHS to the time NEMHS's ambulance arrives at the incident". The data in Table 6 seems to reflect that this is "travel to scene time." As mentioned above, response time had engendered much discussion on how it is computed in recent time leading up to this Project. NEMHS indicated that, as a result, the Camden/Rockport agreements contained a change to response time reporting which was "notified to arrival" time, while the other two contracts retained the above language. This should be addressed if NEMHS continues service to the towns in the next year.

Table 6

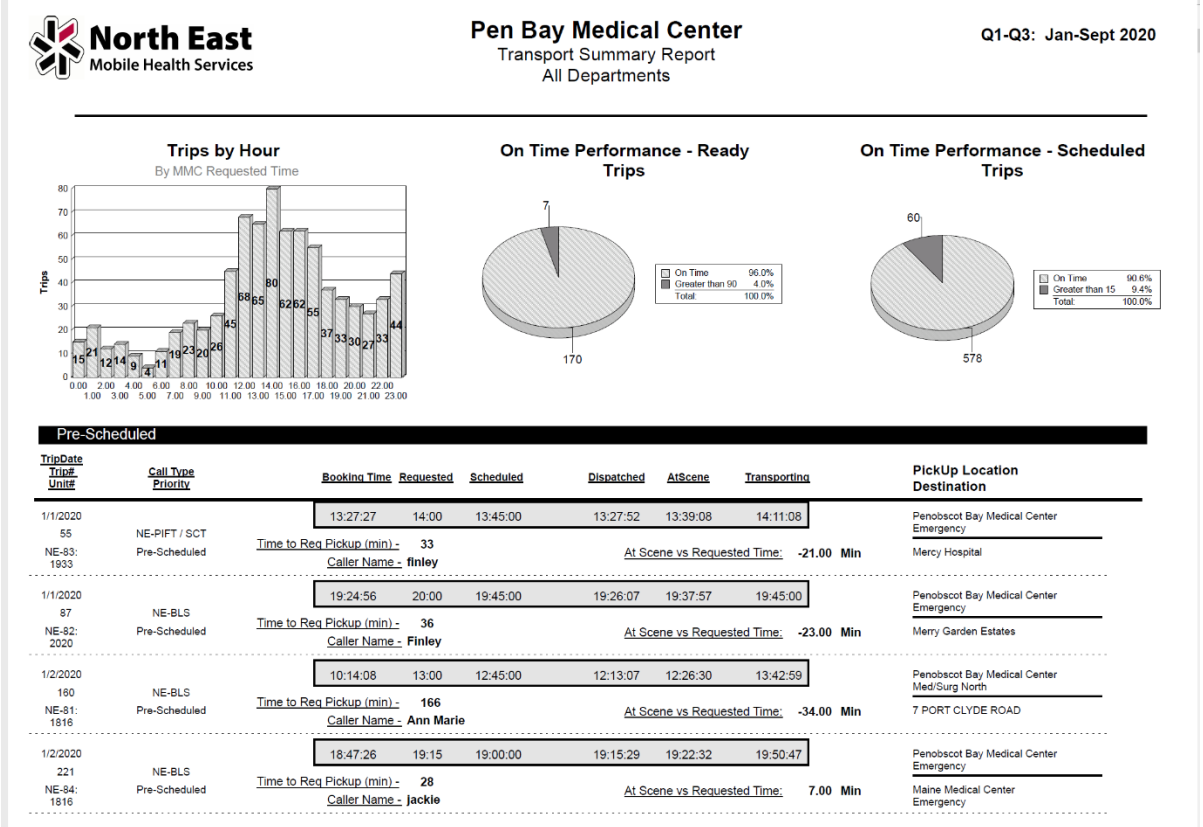
Average Response Time by Town*

***Contract Requirement:** Each town will have an **Average** response time measured quarterly. Fiscal year begins July 1st.

Contractual Time		Contractual Time		Contractual Time		Contractual Time	
Camden: 9 minutes		**Hope: 17 minutes**		**Lincolnville: 19 minutes**		**Rockport: 9 minutes**	
Month	**Ave. Response Time**	**Month**	**Ave. Response Time**	**Month**	**Ave. Response Time**	**Month**	**Ave. Response Time**
July '19	07:33.0	July '19	16:09.0	July '19	15:39.0	July '19	06:23.0
Aug '19	08:04.0	Aug '19	13:30.0	Aug '19	15:40.0	Aug '19	06:04.0
Sept '19	07:27.0	Sept '19	-	Sept '19	20:00.0	Sept '19	07:43.0
Q1	**07:40.0**	**Q1**	**15:11.0**	**Q1**	**16:14.0**	**Q1**	**06:39.0**
Oct '19	07:15.0	Oct '19	11:20.0	Oct '19	13:44.0	Oct '19	06:10.0
Nov '19	08:04.0	Nov '19	14:00.0	Nov '19	18:14.0	Nov '19	06:11.0
Dec '19	07:52.0	Dec '19	17:00.0	Dec '19	19:26.0	Dec '19	06:02.0
Q2	**07:40.0**	**Q2**	**13:17.0**	**Q2**	**17:22.0**	**Q2**	**06:08.0**
Jan '20	07:38.0	Jan '20	15:23.0	Jan '20	15:50.0	Jan '20	06:25.0
Feb '20	07:47.0	Feb '20	13:52.0	Feb '20	16:47.0	Feb '20	06:37.0
Mar '20	07:57.0	Mar '20	14:05.0	Mar '20	16:55.0	Mar '20	05:15.0
Q3	**07:48.0**	**Q3**	**14:35.0**	**Q3**	**16:37.0**	**Q3**	**06:09.0**
April '20	07:20.0	April '20	11:45.0	April '20	15:35.0	April '20	05:35.0
May '20	06:50.0	May '20	12:56.0	May '20	15:46.0	May '20	07:32.0
June '20	07:16.0	June '20	13:13.0	June '20	15:25.0	June '20	06:34.0
Q4	**07:10.0**	**Q4**	**12:47.0**	**Q4**	**15:37.0**	**Q4**	**06:40.0**
Annual	**07:37.0**	**Annual**	**13:50.0**	**Annual**	**16:24.0**	**Annual**	**06:23.0**

Table 7 presents a standard report NEMHS indicates it has provided PBMC for its interfacility transport (IFT) support despite its formal contract having lapsed in 2018. The report indicates compliance with provisions made in the earlier contract to respond a transport crew to PBMC within 15 minutes of the agreed upon time for a "scheduled" call (in this 9-month report 91% of the time), and within 90 minutes for a "ready trip" (an unscheduled IFT request (in this report 96% of the time). The report also provides a list of the IFTs accomplished during the period. When asked for data documenting the IFT activity from the PBMC point of view, an IFT call log similar to NEMHS' list of calls was presented, but no aggregated or analyzed data were available. This call log included calls that NEMHS was not able to make and presented insights into such events that supported interview accounts by PBMC ED staff of the types of difficulties encountered in arranging occasional IFTs.

Table 7



North East Mobile Health Services

Pen Bay Medical Center
Transport Summary Report
All Departments

Q1-Q3: Jan-Sept 2020

Trips by Hour
By MMC Requested Time

On Time Performance - Ready Trips

On Time Performance - Scheduled Trips

Pre-Scheduled

TripDate / Trip# / Unit#	Call Type / Priority	Booking Time	Requested	Scheduled	Dispatched	AtScene	Transporting	PickUp Location / Destination
1/1/2020 / 55 / NE-83: 1933	NE-PIFT / SCT / Pre-Scheduled	13:27:27	14:00	13:45:00	13:27:52	13:39:08	14:11:08	Penobscot Bay Medical Center Emergency / Mercy Hospital
		Time to Req Pickup (min) - 33			At Scene vs Requested Time: -21.00 Min			
		Caller Name - finley						
1/1/2020 / 87 / NE-82: 2020	NE-BLS / Pre-Scheduled	19:24:56	20:00	19:45:00	19:26:07	19:37:57	19:45:00	Penobscot Bay Medical Center Emergency / Merry Garden Estates
		Time to Req Pickup (min) - 36			At Scene vs Requested Time: -23.00 Min			
		Caller Name - Finley						
1/2/2020 / 160 / NE-81: 1816	NE-BLS / Pre-Scheduled	10:14:08	13:00	12:45:00	12:13:07	12:26:30	13:42:59	Penobscot Bay Medical Center Med/Surg North / 7 PORT CLYDE ROAD
		Time to Req Pickup (min) - 166			At Scene vs Requested Time: -34.00 Min			
		Caller Name - Ann Marie						
1/2/2020 / 221 / NE-84: 1816	NE-BLS / Pre-Scheduled	18:47:26	19:15	19:00:00	19:15:29	19:22:32	19:50:47	Penobscot Bay Medical Center Emergency / Maine Medical Center Emergency
		Time to Req Pickup (min) - 28			At Scene vs Requested Time: 7.00 Min			
		Caller Name - jackie						

Maine EMS data report "response time" for IFT calls. These are not significant indicators in and of themselves because there is no definition of whether these involve "ready now," "scheduled," or other types of calls. These 2018-19 response times range from 15 minutes for PACE and Central Lincoln County services, and 15.7 minutes for Belfast Fire, to 18.7 for NEMHS. Emergency department staff who work at both Miles Hospital, served by Central Lincoln County, and PBMC favor the former's IFT performance during interviews over NEMHS' despite the small difference in times reported here.

Tables 8 and 9 describe the volume of NEMHS' IFT activity from PBMC to other facilities in 2019 according to Maine EMS data. Table 10 summarizes these, with Table 4's data on 9-1-1 calls, totaling the 2,606 calls that Maine EMS data indicate NEMHS responded to in 2019.

Table 8

NEMHS IFTs from PBMC to Hospitals	2019
Maine Medical Center	295
Other Facility	52
Waldo	32
Eastern Maine Medical Center	20
Maine General Augusta	18
Lincoln Health	15
Boston Area Facilities	14
VA Togus	14
Central Maine Medical Center	13
Acadia Hospital	8
New England Rehab. Center	7
Mid-Coast Hospital	5
St. Mary's Hospital	5
Dorothea Dix Psych. Center	2
Total	**500**

Table 9

NEMHS IFTs from PBMC to Nursing/Rehab. Homes	2019
Sussman House	116
Windward Gardens	113
Penn Bay	105
Woodlands	72
Knox Center	55
The Garden	33
Bella Point	12
Quarry Hill	10
Crawford Commons	8
Harbor Hill	7
Country Manner	6
Other	8
Total	**545**

Table 10

Total NEMHS Calls by 9-1-1 and IFT Origin	**2019**
9-1-1 Calls to Camden, Hope, Lincolnville and Rockport	1,561
IFT Calls from PBMC to Other Facilities	1,045
Total NEMHS Calls in Project Towns and PBMC	**2,606**

VI. North East's Other Capabilities and Performance

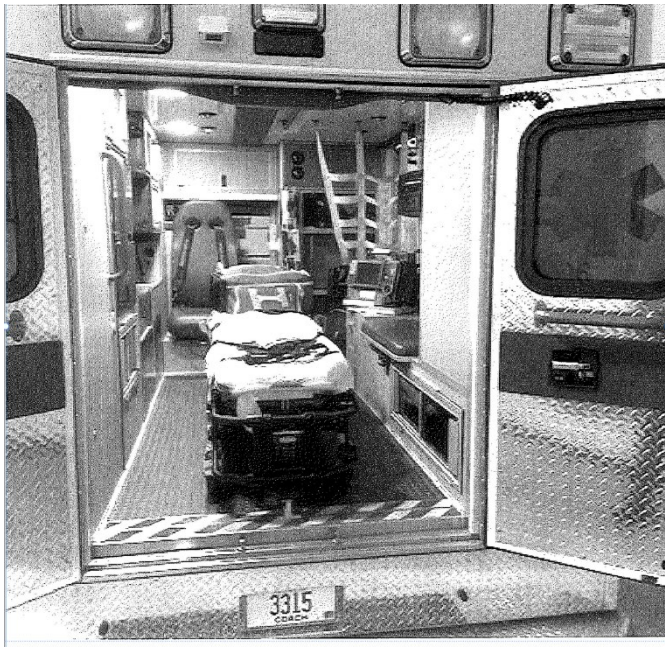
The NEMHS Rockport base was inspected and formal interviews of leadership and a sampling of staff carried out in October, 2020 by Mike Senecal. Additional staff input was solicited informally at other times during the Project.

The inspection found the vehicles and garage space seen in Picture 1, above. Vehicles, garaging facility, and equipment and supplies aboard the vehicles and in storage were found to be clean, operable, well-organized, contemporary and exceeding the requirements of Maine EMS, the State licensing agency. Pictures 1 to 5 reflect this for the EMS-uninitiated. An electronic EMS manager application is used for ambulance and equipment inspections. Electronic and other records of routine vehicle, equipment and supply inventorying and inspection were consistent with these findings with minimal non-compliance noted. Interviews were also consistent with these findings, though indicated that in past periods of absence of a base manager, or ineffectiveness of base managers, compliance with inventorying and inspection procedures varied with crews on duty. By all accounts, this has improved under the current base manager.

The base facility is contemporary construction for the purpose it serves, though lacking dedicated kitchen/dining, bathroom/shower, equipment cleaning, and laundry facilities which would bring these to a more reasonable base of operations for busy crews, and easier to comply with standards of cleaning and disinfection of equipment, uniforms, and other necessities.

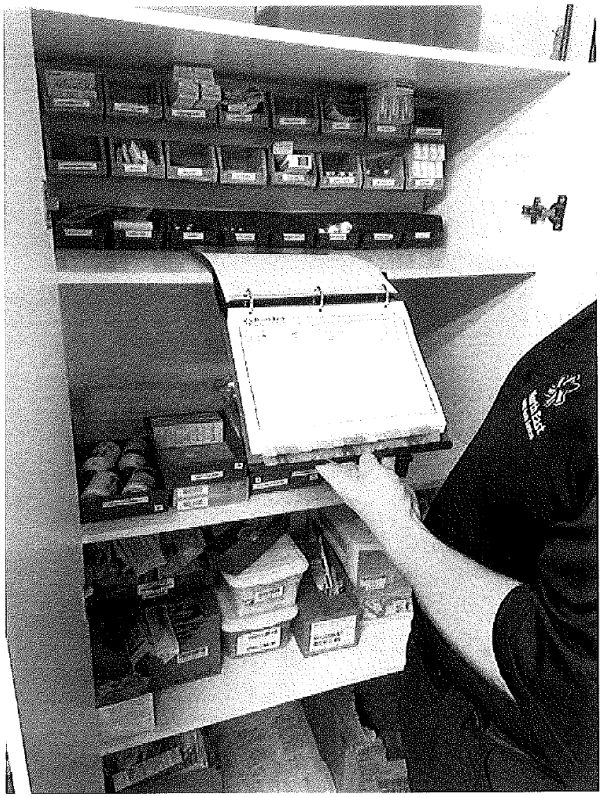
Leadership interviews reflected plans to update these aspects of the base prior to the pandemic, and a renewed intention to do so. Important to a number of supervisory-centric criticisms in interviews mentioned in this section, leadership has stated its intent to maintain an effective base manager as a high priority and to add shift supervisory leaders to help make this position more manageable.

Picture 2 – Ambulance Compartment with Patient Extrication Equipment



Picture 3 – Ambulance from Rear Loading Doors

Picture 4 – Ambulance Kits Storage



Picture 5 – Small Supplies Storage and Log

North East Mobile Health Services formed as an enterprise under Charles McCarthy and his partner, Dennis Brockway in 1999. They were also leaders in the development of Capital Ambulance which originated in the Augusta area, moved its headquarters to Bangor and is now Northern Light Medical Transport, affiliated with the health care system of the same name. The operating, licensure, and character history, records and reputations of these two major EMS operations, and the nature of the involvement of its principals in state system development all lend the current NEMHS operation a degree of credibility as a service operator. Therefore, the underpinnings of an ambulance service in jeopardy (the usual focus of an ICDS process) are not in question, nor did the proprietary aspects of NEMHS' governance, financial, and other corporate aspects demand attention. Operational guidelines and procedures, training and education requirements, safety and other practices have been in place without challenge by Maine EMS or regional quality improvement entities in the two decades of its history. These were not, therefore, considered to be necessary to explore in detail beyond surface inspection and interview verification by leadership and staff. Issues that were revealed are indicated below.

System status management is a concept employed in EMS to anticipate needs for EMS response and to move and stage ambulances accordingly. This is more widely deployed and better understood in larger urban/suburban response areas than in more rural areas with fewer EMS resources. While NEMHS does not utilize such a system formally, its dispatch and internal communications center, MedComm (which also dispatches LifeFlight and other ambulance services), does have computer-aided vehicle location, communications and deployment tools. As mentioned previously, moving vehicles and crews between bases in Brunswick and Rockport is a frequent occurrence. Related issues include crews unfamiliar with the Rockport base response area responding to 9-1-1 calls, and crews transporting patients to Portland being caught up in other calls in that area rather than returning to Rockport immediately. Otherwise, MedComm seems to serve this informal system management system adequately.

Communications are a persistent issue in three areas already reflected or reflected below:

1. System Radio and Other Communication: NEMHS uses the MedComm center in Bangor for most of its dispatching needs. It tries to integrate this system with the KRCC dispatch system in Knox County and with an "I am Responding" application commonly used by public safety in the County to track the status (availability and location) of emergency units. This does not always work well. NEMHS staff are frustrated that KRCC won't call MedComm when it dispatches an NEMHS unit, and Knox County staff and some departments don't feel that NEMHS uses the "I am Responding" application as it is intended. The importance of such coordination belies the fact that this has been going on for several years.
2. Leadership Communications: There is a lack of routine communication among town, fire department, and PBMC leaders and NEMHS. NEMHS staff cite a weak town attendance at EMS Performance Review Advisory Committee process meetings that should be a venue for discussion, problem-solving, and updating. They show their efforts at routine reporting which evidences contract compliance and willingness to discuss and resolve issues. Some town and PBMC leaders

characterize NEMHS as being weak on responding to problems and follow-through on promised initiatives. Other towns' officials have indicated that NEMHS leadership has been accessible and reliable on follow-through. NEMHS officials seek a consistent point of contact in PBMC administration as well as that which it has in the emergency department. PBMC emergency department leadership seek a more routinely accessible and present point of contact at the Rockport NEMHS base.

3. Intra-service Communications – The communication issues cited in interviews below.

Finally, with issues raised about staff performance during interviews with some fire and PBMC staff, quality improvement (QI) was reviewed. We were told by leadership that all service studies for Rockport Division have focused on response time performance (and are described above). There have been studies of individual performance. They added that NEMHS has just signed into a second year of an agreement with APEMS for training. This year they added into the agreement skills verification, that will make it mandatory for all licensed EMS personnel to pass an independent, third party skills verification.

Interviews with NEMHS staff consisted of formal sit-downs with on-duty and other staff designated by NEMHS and some informal conversations with other current staff. While staffing issues were often mentioned as a source of response time and mutual-aid-overuse concerns mentioned by fire service officials interviewed, they were not reflected in concerns about pay levels or working conditions of those interviewed. Yet a common refrain from staff was the loss of "the best paramedics" to fire services in the state.

Common themes from NEMHS staff interviews were:

- Feelings of isolation from the rest of NEMHS and being treated as second class considerations, especially feeling that base managers were actually or effectively absent in communicating for them with upper management in Scarborough.
- Lapses in leadership providing performance, administrative and training oversight. Many felt that crews had been left to govern and make decisions for themselves that should have been a base manager's job.
- A mix of receptiveness from staff at PBMC emergency department, making for uncertain relationships for some NEMHS staff.
- Morale suffers with an absence of local leadership and regular communication from Scarborough. There has been a feeling over a few years of "who speaks for us and our base's needs?"
- Training offerings were characterized by most as good up until the pandemic began.
- Constant pressure to "be here right away" for interfacility transports from PBMC.
- Getting stuck in the Portland/Maine Medical Center (MMC) "vortex" when on an IFT to MMC is frustrating when crews feel urgency to be available in Rockport.
- A negative working environment with some fire chiefs on scenes and as a result of their comments in the press and at town meetings.

- Otherwise, there seems to be a generally a good working relationship with most fire and law enforcement staff on scenes, and with long-term facility staff in most situations. That said, when there is hostility, it seems to be passed from certain fire officers down through the ranks.
- New equipment availability requests sometimes not answered.
- Many of the lapses cited above were also mentioned as having improved with the current base manager.

Finally, interviews with area public safety responders, town officials, businesspersons, and nursing/convalescent health care facilities staff added the following:

- Those not involved in public safety or town government generally had neutral or positive attitudes about NEMHS as their ambulance service. Some mentioned missing the familiar faces of, and a community-based service like CFAA, but also acknowledged financial and management issues to which that particular service had subjected the community in terms of.
- Those involved in public safety or town government, more so in Camden and Rockport than Hope and Lincolnville, had general impressions that developing a fire-based EMS agency, perhaps regionally, would be the right direction in the long run. Again, there was a positive attitude expressed toward a community-based service as opposed to a statewide service.
- There were many criticisms expressed by fire service and PBMC staff about individual NEMHS crew members and their performance, readiness for the work involved, knowledge of the response area and its towns and people. Some of this was directly observed and some second-hand accounts, so it was difficult to judge how pervasive these impressions were. It seems that many stories were facilitated by a few because of the consistency of the accounts. No accounts rose to the level of local, regional, or Maine EMS attention to our knowledge.
- Local health care facility staff expressed primarily positive relationships with NEMHS staff.

VII. Camden-Rockport-PBMC: Options to Meet Community Needs for an Agile, Responsive EMS Resource

Following the evaluative work described above, the Project Steering Group assessed the information available and made some initial findings from which options could be developed. With those findings presented, staff analyzed these and all information gathered to date, and took the NEMHS organization and other resources in the four town Project area as profiled in the previous two sections, and analyzed their strengths and weaknesses as well as their opportunities and challenges (an informal "SWOC analysis"). This information enabled staff to develop an initial set of options for the Steering Group to consider.

What follows are:

- The Steering Group/staff findings,

- The staff SWOC analysis,
- The options initially considered,
- The description of the option selected and the process by which it was considered by Town and PBMC decision-makers,
- The resulting NEMHS contract provisions sought by the Steering Group, and
- The draft contracts offered by NEMHS following discussions about the provisions wanted by the Steering Group.

The significant ***findings*** by the Steering Group included:

- The evaluation process response-related data analysis did not uncover issues with NEMHS performance in meeting 9-1-1 response expectations that required immediate or major intervention. An organized first responder capability could be beneficial, particularly in outlying areas, but efforts to implement this do not seem to have succeeded. Anecdotal interview accounts of issues with NEMHS personnel behavior, attitudes, patient care, communications practices, and readiness on calls were encountered but seemed not to rise to regional EMS attention for intervention. Those reporting such issues attributed them to a lack of consistent supervision in recent years. The preponderance of interview input indicated generally reasonable performance by NEMHS staff on calls.

- Issues with IFT performance were difficult to evaluate beyond the anecdotal input from interviews but seemed to be similar to those experienced in other areas of the state. Potential worsening of this situation by pandemic considerations and patient movement within health systems further clouded this aspect of the operation. Aggregating IFT data collected in a log in the emergency department would be useful. NEMHS officials would like a more defined and contemporary set of expectations by which to operate since the one formal contract expired in 2018. They seek to enhance a communications channel in administration as well as that for day-to-day operations with emergency department staff.

- Interviews with Hospital personnel consistently reflected frustration with the process for securing IFT service from NEMHS through MedComm, concerns about inconsistent patient care and communications from the field for patients brought by NEMHS crews to the Hospital, and a consistent sentiment that Rockland Fire and other towns' crews were "professional" and NEMHS crews were less so. This was frequently attributed to lack of base supervision and use of transient employees and crews from other NEMHS bases. It was also frequently noted that in the first years after NEMHS started 9-1-1 service, base supervisors made themselves frequently available at check-in rounds in the ED and at times when IFT demands were high to manage resources. This has eroded in the past few years. A similar effect was noted in reported NEMHS personnel relationships with fire service personnel over the years. Hospital staff with emergency department responsibility uniformly said that they would welcome NEMHS crews in the ER to help or train between calls.

- Interviews with PBMC officials generally indicated that hospital investment in its own EMS capability for IFT, while considered in a meeting process with another Maine Health system hospital-based ambulance service, does not appear to be an option in the current health system reimbursement and pandemic environments.

- The degree to which NEMHS meets its contractual and other service commitments is subject to accountability issues inherent in the terms of the existing contracts. It has met those terms according to response time and staffing reports provided to the Towns periodically. Renewed agreement about those terms; more frequent and consistent meetings for performance reporting and discussion among the Towns, Hospital and NEMHS; and a reliable process for issue-reporting and resolution would be beneficial. Response time reporting should be based on dispatch to at scene time by KRCC and used in contracts, but additional response measures such as fractile time reporting should be added.

- There is consistent anecdotal evidence from interviews that the lack of a consistent and sustained supervisory presence at the NEMHS base in Rockport over a period of years has impaired communications with hospital and town personnel. This may have contributed to additional anecdotal reports of issues with NEMHS personnel performance and service response performance as well as apparent lack of effectiveness in resolving at least some of them. Substituting in NEMHS leadership staff at the base on a transient basis seems to have been an inadequate solution for assuring routine communication and trust among stakeholders and clinical and operational oversight of field staff. NEMHS intentions to have levels of base management and shift supervisory staff should be carried out.

- There is consistent anecdotal evidence from the interview process that NEMHS experienced problems with filling staffing vacancies at times. This was often mentioned in relation to concerns about meeting response time expectations and dependence on Rockland Fire EMS mutual aid. Over a two-year period to mid-2020, Rockland Fire reported a mutual aid rate for the NEMHS response area of just under once a week. Again anecdotally, these issues have become less apparent, and Rockland Fire is less concerned about mutual aid frequency than a year or so ago. KRCC staff noted no mutual aid issues when asked.

- There are three tensions involved in the background of the Project:
    - One is naturally between the Hospital and the Towns. This is not hostile, just practical, and both realize they are representing essentially the same patient interests. It is simply that 9-1-1 response and IFT response "compete" for the same ambulance resources.

    - A second tension is between the general competition between fire service and private service for provision of EMS. NEMHS is a private service EMS, and fire service EMS is the method in use in neighboring Rockland. Generally, in this country, neither has been proven superior to the other.

An argument has been made publicly for developing fire service EMS in the four-town Project area as a way to address both fire and EMS needs.

- The third tension is between the smaller Towns and the larger Towns in the Project, and goes beyond EMS provision into any area in which they consider joint provision of a service to their citizens and, among other things, is a perceived ability to afford a service. The interview process revealed more satisfaction with maintaining the NEMHS provision of EMS in the small towns than in the large ones where the possibility of developing a new fire-EMS capability seems to potentially solve fire and EMS provision issues in one package. It also leads to less patience with any issue involving NEMHS.

The staff's informal assessment of strengths, weaknesses, opportunities, and challenges ("SWOC") of NEMHS and other EMS system resources in the four-town Project area include:

- Strengths:
  - NEMHS is a large service with deep staff, vehicle, financial and other operational resources making it a relatively stable agency with which to contract for service, as well as agile in meeting demand fluctuations.
  - The overall ability of NEMHS to meet contractual obligations has been positively demonstrated and it is willing to enter another contract without significant increase in cost to the towns and, possibly, PBMC.
  - There is a successful fire-based EMS model in Rockland that offers potential operational options in the future by way of example or partnership.
  - Camden Fire officials and NEMHS officials offered operational options for consideration in the future. All of the suggestions fell within known and generally acceptable practices in the EMS field.
  - There has been an unfulfilled potential for a cooperative, four-town first response initiative based in the fire departments and significantly supported by NEMHS (e.g. medical direction, incidentals resupply, and training).
  - There is a new EMS specialty physician at PBMC with responsibility for EMS liaison.
  - There is PBMC emergency department receptiveness to a closer relationship with NEMHS local leadership and staff.

- Weaknesses:
  - The lack of a contractual or other set of mutual expectations between NEMHS and PBMC.
  - Inconsistent understanding and use of the performance measurement components of the NEMHS/town contracts, and dependence on response-time measurement as one of two sole indicators.

- Lack of consistent NEMHS base leadership in Rockport over a multi-year period.
- Negative relationships toward NEMHS responders on scenes and in other settings by some fire officials and their staff.
- Communications challenges on the part of NEMHS officials.
- Failed continuity of EMS Performance Advisory Committee and other routine interactions between town and NEMHS, and PBMC and NEMHS officials.

- Opportunities:
  - After years of being an unfulfilled consideration, creating a first response capability is a reasonable option. Local fire and law enforcement staff have completed EMT training and may be resources to call upon. NEMHS remains supportive of helping to implement this under a cooperative fire-service model. This will enhance opportunities to consider other fire-based EMS options in the future.
  - Rewriting an NEMHS/town contract addressing many of the issues cited in this report can improve them at little or no extra cost.
  - NEMHS has offered contract extensions for the next year or two without significant cost increase.
  - There are realistic alternative proposals for improving EMS provision in the future as offered by fire and NEMHS officials.
  - Models offered by Rockland Fire EMS, Brewer Fire/Northern Light Medical Transport, and Waterville Fire /Delta Ambulance for consideration.

- Challenges:
  - The new contract period begins shortly, on July 1, 2021, limiting implementation of options requiring a longer planning and start-up phase.
  - Many options presented for improving EMS system response involve significant expense increases and require further study, thus limiting their utility this year.
  - The pandemic continues to present operational and financial uncertainty for towns, EMS, and hospitals. This makes it an additionally difficult time to consider wholesale changes in EMS coverage.
  - Strained relationships between fire officials in some of the towns and NEMHS leaders.
  - The costs cited to date of significant changes in how EMS is provided in the area.

Ten initial operational options, **in six general categories**, for 9-1-1 and interfacility transport coverage after June 30, 2021 were drafted for, and considered by, the Steering Group. These were derived from staff team experience with operational models in other, similar settings and considering proposals requested and received from NEMHS and local fire service professionals. Project staff assured confidentiality of the details of any

such proposal, and the details below do not provide any information other than those previously presented in public by others.

Details of the options considered by the Steering Group, such as pros and cons considered, are displayed in Appendix A.

The costs associated with each option are magnitude estimates only. The current total contract cost for the Towns is, per NEMHS, $298,997 plus a .5% CPI boost for 2020-2021, or $300,492. There is no current cost to the Hospital.

The options for 2021 to 2022 (or 2023) that were discussed fell into the following six general categories with ten total options. The costs attached to each were a combination of staff estimates and comparison with information proposed by NEMHS or fire officials in their proposed solutions. These costs were revised as the options were considered, but remained general estimates of anticipated expenses and revenue by Project staff. In Option 2.0, the cost estimate for the first response unit changed significantly in later stages of consideration as the towns felt that they could individually supplant some of the costs estimated. The options considered were:

- **1.0 Status Quo** – Essentially just renew the NEMHS contracts as the sole provider for 9-1-1 with the Towns and IFT with the Hospital. $311,000. This figure includes a 3.5% CPI-based estimate from NEMHS which may be negotiated.

- **2.0 NEMHS Primary Provider with Fire-Based First Response, Service Improvements and Regional Planning Initiative** – Town and Hospital contracts would be revised to include contemporary performance accountability and issue resolution measures, base supervision assurance, and other improvements indicated by the evaluation. A fire-based first response capability would be developed in cooperation with NEMHS and the four Towns' fire departments. This would enhance response time performance and staffing availability at a cost commensurate with the modest indicated need, as well as a foundation for further fire-based EMS development if that becomes indicated. The contract may extend for two years to enable a planning process to explore regionalization of EMS service to enhance efficiency and effectiveness of EMS and fire response capabilities. General magnitude of cost estimate: $350,000 - $400,000 ($311,000 for NEMHS contract plus first response start-up and regionalization planning initiative costs). This includes an estimate for the first response and planning initiatives which need to be refined before going to budget decision-making.

- **3.1-3.3 NEMHS Sole Provider with Enhanced Crew Coverage** – Continue NEMHS contracts with improvements discussed in 2.0, and fund increased pay for NEMHS staff to be competitive, fund an additional 24/7 ambulance coverage, or fund both. General magnitude of cost $.85 million to $1.4 million ($311,000 of NEMHS contract cost plus additional expenses) depending on solution selected.

- **4.1-4.2 Fire-Based Sole Provider for 9-1-1 and IFT** – Start up and operate an EMS unit from either Rockland Fire/EMS or Camden Fire to cover 9-1-1 and IFT response. Ambulances would be maintained in Camden and West Rockport stations. Crews would be mixed departments depending on option selected. $1.2 million start-up (largely capital) costs and $1.2 million annual operating costs. Cost could be somewhat less if operated from Rockland. Revenue from all calls is included as a deduction from costs cited.

- **5.1-5.2 Fire-Based 9-1-1 EMS/NEMHS Based IFT** – Continue to operate IFT as a NEMHS service. Start up and operate 9-1-1 response as a fire-based service from either Rockland Fire/EMS or Camden Fire. Ambulances would be maintained in Camden and West Rockport stations. Crews would be mixed departments depending on option selected. $600,000 start-up (largely capital) costs and just under $1 million annual operating costs. This is cost after revenue for 9-1-1 calls deducted. Cost could be somewhat less if operated from Rockland.

- **6.0 Mixed NEMHS and Fire-Based Response (and Possibly Hospital Based Participation) –** Multiple options possible using a model employed by Brewer Fire and Northern Light Medical Transport for several years and more recently instituted by Waterville Fire and Delta Ambulance. This would have one or more agency providing the vehicles, and one or more agency providing the staff (for example, a fire/EMS agency driver and a NEMHS paramedic). Cost estimates vary with exact model selected and whether used for 9-1-1 response only or for both 9-1-1 and IFT.

The Steering Group made the following determinations and option selection:

- Rejected option 1.0 as unresponsive to issues made evident by the Project evaluation. This would ignore legitimate concerns revealed by the Project evaluation.

- Chose not to pursue options 3.1-3.3 at this time as their cost did not seem justified by the findings of the evaluation as to the problems potentially addressed (NEMHS staff pay and number of units covering). The response time data did not present the picture of a problem that necessitated or would be impacted by a sweeping staff pay increase or the addition of another 24/7 staffed ambulance.

- Chose not to immediately pursue options 4.1-6.0 because:
    - they would be unlikely to be successfully approved and implemented by July 1, particularly under the current process limitations imposed on town budget approval functions and impacting the provision of EMS and Hospital services under the pandemic,

    - they may involve a magnitude of costs not found to be merited by the findings of the Project evaluation (e.g. response time data) and difficult to explain and justify to decision-makers including taxpayers, and

- some of the options involve components targeting improvement of fire-response readiness not able to be addressed by the Project.

- Chose to pursue option 2.0, referring options 4.1-6.0 to the regionalization planning process integral to that option, because:
  - It most directly addresses the issues cited by the evaluation as accountability/supervision/response/communication problems at a cost commensurate with those issues (for example, subject to negotiation with NEMHS most issues may be addressed at minimal contractual cost; also, since response time for 9-1-1 calls does not appear to be a critical problem, creating a fire-based first response capability able to provide basic life support a couple to several minutes before ambulance arrival (depending on location and circumstances) and to provide extra hands in some situations, is justifiable at the cost anticipated.

  - It establishes a foundation for further fire-based EMS development (drawing on local personnel already recently trained) if elected following the regionalization planning process, and

  - It assures continuity and improvement of EMS service during a period adequately long to consider alternative regional models of 9-1-1 and IFT response provision.

- Following an analysis of different ways of apportioning costs of Option 2.0 to the towns, the Steering Group selected to continue using the population-based apportionment of costs for the NEMHS contract, for the regionalization planning project and for the shared administrative costs of the first response unit start-up costs. Costs of call-pay and equipping the first response for responders would be individually budgeted and managed by the towns.

- The financial impact of this option for the towns would be:
  - A .6% increase for the NEMHS contract for 2021-22 based on the New England Consumer Price Index,
  - A population apportioned split of $20,000 for the regional planning initiative,
  - A population apportioned split of $1,200 for the first responder unit administrative costs.

Table 11

Town	2010 Population	2010 Population %	2019-20 NEMHS Contract	2020-21 NEMHS Contract	2021-22 NEMHS Contract	2021-22 Regionalization Plan Initiative	2021-22 1st Responder Admin. Costs
Camden	4,851	41%	$122,066	$123,202	$123,941	$8,200	$492
Rockport	3,330	28%	$83,810	$84,138	$84,643	$5,600	$336
Lincolnville	2,164	18%	$54,463	$54,089	$54,413	$3,600	$216
Hope	1,536	13%	$38,658	$39,064	$39,298	$2,600	$156
Total	11,880	100%	$298,997	$300,492	$302,295	$20,000	$1,200

The Steering Group chose to utilize a select board/town referendum process for decision-making on enacting the option selected. This was consistent with annual planning and budgeting processes in the towns under the pandemic restrictions on public meetings. Informational meetings were held virtually on this subject for the Camden select board, Rockport/Lincolnville/Hope select boards, and again separately for the Hope select board and budget committee. The Rockport select board also hosted an informational session attended by Project staff on the contract it would enter with NEMHS. All sessions were open to the public and were well attended, including by town fire and committee officials.

Contract provisions were drafted by staff and the Steering Group once the informational meetings were held and the option presented received no objections. The Steering Group's desired contract provisions were discussed with NEMHS and a final set conveyed to NEMHS (see Appendix B for this document). NEMHS officials then drafted a contract which was discussed with staff and then the Steering Group. A final draft contract for each town was discussed by staff and NEMHS officials and then presented to the towns. These are found in Appendix C. The Steering Group agreed that at least one town attorney from Camden and/or Rockport would review the contract provisions. Further contract discussions would be held between NEMHS and the towns directly.

There was no new PBMC/NEMHS contract developed in the Project. However, a relationship was established between the PBMC EMS liaison, Dr. Skinner, and the NEMHS CEO, Mr. Russell. They held an initial meeting with further ongoing discussions planned to address the findings of this Project.

Appendix A. Original Options Considered by Steering Group

Addendum: Original Options Discussed (From 12/10 Steering Group Meeting)

Option Development

- ***1.0 NEMHS Sole Provider Status Quo***
  - Baseline Current (2019 - 2020) Service Level/Cost:
    - Cost: $298,997 + .5% CPI = $300,492 (Towns Subsidy)
  - 1.0 Status Quo (2021 – 2022) Service Level/Cost:
    - Cost: $300,492 + 3.5% CPI = **$311,009**
- ***2.0 NEMHS Sole Provider – Strong Interview Based Improvements***
    - Cost: $300,492 + 3.5% CPI = **$311,009 ($336,009** with First Response Option) Annual Operating
      - Option: First Response Incentives: Total - $25,000
        - ***This is only an example.*** If first response is chosen to be developed, it will need to blend with current FD procedures and payment schemes.
        - Call pay: 1,000 Responses @ $15 = $15,000
        - Equipment/Supplies: 25 Responders @ $100 = $2,500
        - Insurance, training, miscellaneous: $7,500
    - Improvements:
      - Accountability:
        - Response Time and Other Contractual and Reporting Provisions
        - Town and FD Coordination/Performance Review Meetings
        - Supervisor/PBMC Staff Routine Meetings
        - First Response Capability Development
      - NEMHS Base Supervision
        - Position Continuity is a Priority
        - PI/QI Measures to be Utilized
      - NEMHS Staff Downtime Utilization
        - Integrate with PBMC ED/Other On-Site
        - Operate a Truck from Camden FD
      - Continue Regional Approach Assessment/Planning

        - Cost of Facilitator/Fire Service SME/EMS SME?
    - Pros/Cons:
        - Pros
            - Cost Stability
            - Least Complicated/Intrusive Under COVID Challenge
            - With First Response Option, Begins to Integrate FDs into EMS Response Formally
            - Potential to Address Issues Raised
            - Possible Impact on Response Times
            - Interim Path to Considering Regional/FD Options
        - Cons
            - May Not Address All Staffing Issues Raised by Some
            - May Not Address Unit Availability Issue Raised by Some
            - Doesn't Otherwise Address FD Model for EMS

- ***3.0 NEMHS Sole Provider - Mixed Interview Based Changes***
    - 3.1 Increased Coverage by 24/7 Unit (no base pay increase)
        - Cost: $300,492 + $475,000 = **$775,492** Annual Operating
    - 3.2 Increased Base Pay (no increased 24/7 coverage)
        - Cost: $300,492 + $205,000 = **$505,492** Annual Operating
    - 3.3 Increased Coverage by 24/7 Unit and Increased Base Pay
        - Cost: $300,492 + $755,000 = **$1,055,492** Annual Operating

        - Pros/Cons
            - Pros
                - May Address Staffing Issues Raised by Some
                - May Address Unit Availability Raised by Some
                - May be Stronger Interim Measure Than 2.0
            - Cons
                - Additional Unit Without Additional Pay May Not Attract Sufficient Staff
                - Competition for Local Staff
                - Data Consistent With Solution?

        - Ability to Explain Solution

- ***4.0 Fire-Based EMS Sole – 911 and IFT***
    - 4.1 Camden FD Hub and Rockport Station
        - Cost: $1,185,000 Capital Start-up; $1,220,000 Annual Operating
    - 4.2 Rockland FD Hub and Spoke
        - Cost: Less than 4.1

        - Pros/Cons
            - Pros
                - Local "Ownership"
                - Possible Response Time Improvement
                - Possible Assistance to Fire Coverage
                - Regional Solutions Are Potentially More Effective and Efficient – Rockland or Countywide Approach is Worth Further Study
                - Rockland Hub Plan Brings Experienced Fire-EMS Organization
            - Cons
                - Implementation Difficult in Current Time-Frame and Under COVID Environment Uncertainty
                - Competition for Local Staff
                - Data Consistent With Solution?
                - Ability to Explain Solution
                - Local Hub Lacks Fire-EMS Developmental Experience

- ***5.0 Fire-Based 911 EMS/NEMHS Based IFT***
    - 5.1 Camden FD Hub and Rockport Station
        - Cost: $600,000 Capital Start-up; $990,000 Annual Operating
    - 5.2 Rockland FD Hub and Spoke
        - Cost: Less than 5.1

        - Pros/Cons
            - Pros
                - Local "Ownership" for 911 Response

        - Possible Response Time Improvement
        - Possible Assistance to Fire Coverage
        - Regional Solutions Are Potentially More Effective and Efficient – Rockland or Countywide Approach is Worth Further Study
        - Rockland Hub Plan Brings Experienced Fire-EMS Organization

    - Cons
        - Implementation Difficult in Current Timeframe and Under COVID Environment Uncertainty
        - Competition for Local Staff Even More so Than 4.0
        - Data Consistent with Solution?
        - Ability of NEMHS to Attract Staff for Interfacility Only Work
        - Local Hub Lacks Fire-EMS Developmental Experience

- ***6.0 Mixed NEMHS and Fire-Based/Possible Future Transition***
    - Cost: Too vague to be estimated at this time. Many options.

    - Pros/Cons
        - Pros
            - Brewer/Waterville Mixed Approaches Have "Sold" in Other Communities
            - Local "Ownership" Introduced
            - Possible Assistance to Fire Coverage
            - Regional Solutions Are Potentially More Effective and Efficient – Rockland or Countywide Approach is Worth Further Study
        - Cons
            - Implementation Difficult in Current Time-Frame and Under COVID Environment Uncertainty

- Data Consistent With Solution?

Appendix B – Steering Group Approved Provisions for a New NMHS Contract


Final Contract Gen. Prov.s 3-25-21.pdf

Appendix C – Draft Town Contracts Delivered by NEMHS


Hope EMS 2021- Final Draft .pdf


LincoInville EMS 2021- Final Draft .pd


Camden EMS 2021- Final Draft .pdf


Rockport EMS 2021- Final Draft .pdf

Appendix D - Select Board Information Sessions Slide Program


Version 2.2 Camden-Rockport-Pl

Appendix E - Project Staff Advisors Team

Kevin McGinnis, MPS, Paramedic Chief (Retired)

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 47 years of experience in EMS systems development. Former director of Maine EMS and Maine's E-911 Program, he received the Governor's EMS Award from Governor King in 1997. He authored *"The Rural and Frontier EMS Agenda for the Future"* a milestone book for the federal government and the National Rural Health Association. He coined the term "community paramedicine" a concept now in wide use worldwide. In 2018, Kevin received the *Journal of EMS* "Top Ten Innovator Award". He was named by the Government *Technology/Solutions for State and Local Government* magazine as one of its 2013 "Top 25 Doers, Dreamers & Drivers in Public-Sector Innovation".

He is the past Chairman of the U.S. Department of Homeland Security's SafeCom Program and continues to serve on its Executive Committee. Kevin is Vice-Chair of the Governing Board of the National Public Safety Telecommunications Council and was bestowed its top honor, the Richard DeMello Award, in 2017.

In August, 2015, he was named by the U.S. Secretary of Commerce to a second three-year term on the First Responder Network Authority (FirstNet) Board of Directors and termed out in October, 2018.

Mr. McGinnis has been an ambulance service chief of hospital, private, and volunteer ambulance services in Maine and New York, and has significant paramedic experience with urban, suburban, and rural fire rescue/first responder, and ambulance services. 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 degree from Brown University and a graduate degree from Cornell University, both in hospital and health services administration, and holds or has held a variety of EMS clinical and instructor certifications. He has practiced as an EMT or paramedic throughout most of his career.

Mr. McGinnis has participated as principal consultant, or on federal consulting for state or local EMS system evaluations in Arkansas, Alabama, South Dakota, New York and Montana. As a state (Maine) and regional EMS director, he has evaluated and assisted dozens of EMS operations of every type. He has completed service assessments and strategic planning projects throughout Maine.

Richard Narad, D.P.A., J.D.

Rick Narad is professor of health services administration at California State University, Chico. His research interest is public policy related to the planning, implementation, and management of emergency medical services systems. His publications have included evaluation of ambulance regulatory programs, modeling of changes in the ambulance industry, and a model for comparing public and private services.

Dr. Narad started in EMS administration in 1979. He served as Executive Director of the Merrimack Valley (Massachusetts) EMS Corporation and as EMS Coordinator for Sonoma County (California). He has provided consulting services to state and local governments regarding planning, implementation, and evaluation of EMS systems and has served as an expert witness in cases related to EMS.

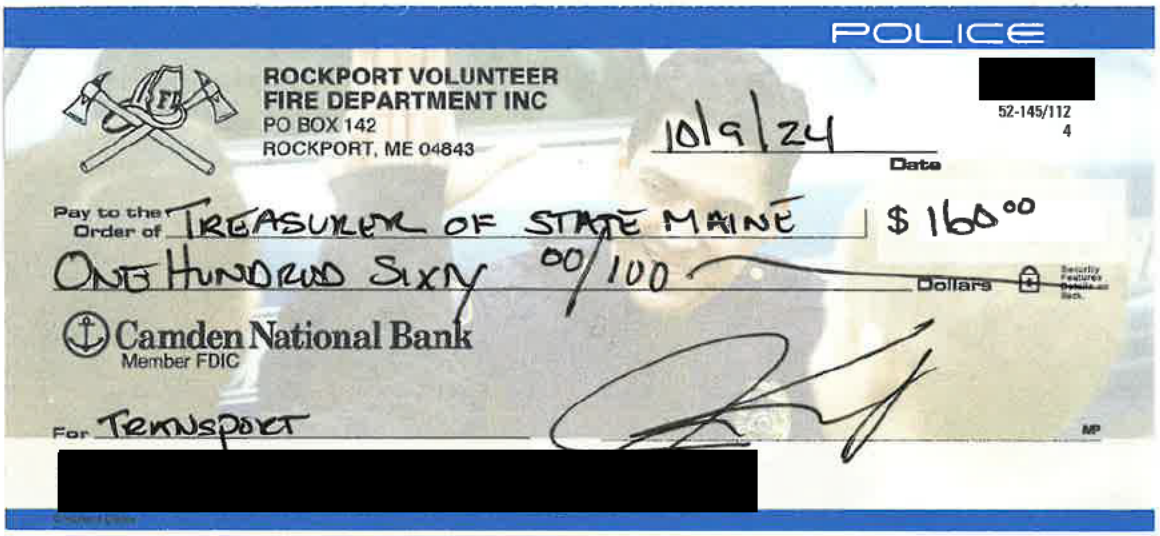
He received an A.S. in Fire Science from Santa Rosa Junior College in 1975 and a B.A. in Health Care Management from CSU, Chico in 1979. He received his MPA., with a specialty in health services administration, and his DPA., with a specialty in health policy, from the University of Southern California. He also received his JD, with a focus on health law, from Concord Law School and is a member of the State Bar of California. He is a Fellow of the American College of Healthcare Executives.

Dr. Narad served as president of the Northern California EMS Administrators Association and as chair of the American Society for Testing and Materials' Committee

on EMS. He was treasurer of the California Association of Healthcare Leaders and a member of the National EMS Museum Foundation Board of Trustees. Currently, he serves as a board member and as an operations manager of Safe Space Winter Shelter and is a member of the California Medical Assistance Team.

Michael Senecal, NRP

Mr. Senecal is the director of North Star Emergency Medical Services, serving Franklin County, Maine. He attended the University of Illinois and Frontier Community College. He has been with North Star for eighteen years, helping to forge it from five separate ambulance services previously serving the county. North Star is operated by Franklin Memorial Hospital, a part of the Maine Health System. Mr. Senecal oversees 85 employees and a budget of $4.3 million. He also serves as the hospital's emergency preparedness coordinator.


POLICE
ROCKPORT VOLUNTEER
FIRE DEPARTMENT INC
PO BOX 142
ROCKPORT, ME 04843
[redacted]
52-145/112
4
10/9/24
Date
Pay to the Order of TREASURER OF STATE MAINE
$ 160.00
ONE HUNDRED SIXTY 00/100
Dollars
Security Features Details on Back.
Camden National Bank
Member FDIC
For TRANSPORT
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November 27, 2024

Acknowledgements

This report was prepared with data and insights provided by the following individuals and resources:

- **Rick Petrie**, Executive Director of Northeast Mobile Health Service.
- **EMS Structured for Quality: Best Practices in Designing, Managing, and Contracting for Emergency Ambulance Service**, Copyright © 2008, American Ambulance Association.
- **Knox County Fire Service Review & Emergency Medical Service Assessment Report**, Draft Report, July 2024, prepared by **Neil D. Courtney**.
- Data supplied by **Maine EMS**.
- **Jason Peasley**, Fire Chief, Town of Rockport, Maine.

My deepest appreciation to all contributors for their exceptional work and willingness to share information that has greatly informed this analysis.

Consultant's Role in Preparing this Report

This report has been prepared by **Charles McMahan, MBA, Paramedic**, an independent third-party consultant with **40 years of experience** in Emergency Medical Services (EMS) at all levels. Mr. McMahan holds an **MBA in Management and Finance** and has held several prominent positions in the EMS field, including **Chief Operating Officer of Capital Ambulance in Bangor, Maine**, and **Regional Operations Manager of Northern Light Medical Transport**. He has also served as the **Chief of Orono Volunteer Rescue Squad** and the **Director of MedComm Dispatch and Billing Operations for Meridian Mobile Health and LifeFlight of Maine**.

With extensive expertise in both **operations management and financial oversight**, Mr. McMahan is well-versed in evaluating the efficiency and sustainability of EMS systems. His deep understanding of the **regional EMS landscape** has informed this report's analysis of Rockport's current and future EMS needs. The recommendations provided are based on a thorough assessment of **response times**, **staffing models**, **financial considerations**, and **regional partnerships**, ensuring that the proposed transporting ambulance service is both **viable** and **beneficial to Rockport and surrounding communities**.

I. Introduction

Purpose of the Report
This report evaluates the transition of **Rockport Fire Department** from providing first-response services to implementing a **municipal-based ambulance transport service**, replacing the current contract with **Northeast Mobile Health Services (NEMHS)**. It examines the readiness of Rockport Fire, the comparative performance of NEMHS, and the broader implications for the EMS system in Knox County. This assessment considers operational, financial, and regional factors to ensure a sustainable approach to emergency medical services.

Overview of Current EMS Landscape
Rockport, with an estimated population of **3,644 residents** as of 2023, is currently served by NEMHS for emergency medical transport, while Rockport Fire has provided first-response services since early 2024. The decision to terminate the contract with NEMHS and establish a local ambulance service introduces opportunities for greater **local control** but also raises questions about Rockport Fire's readiness, NEMHS's ability to sustain services in other towns, and the broader regional EMS landscape.

II. Current EMS Performance Metrics

A. Northeast Mobile Health Services (NEMHS) Performance

Data from NEMHS (2020–2024) highlights consistent performance in response times and paramedic coverage:

- **Response Times**:
  NEMHS consistently met Rockport's contracted response time standard of **11 minutes**, with a **2024 YTD average response time of 7:00 minutes**.
- **Paramedic Availability**:
  Nearly **100% paramedic coverage** for high-priority (C/D/E) calls over the past five years.
- **Mutual Aid**:
  Mutual aid requests to other area EMS agencies for Rockport calls have been low, averaging fewer than **10 per year**, with as few as **3 requests in 2024 YTD**.

B. Rockport Fire Department Performance

Rockport Fire began first-response EMS operations in 2024. Initial response time data indicates comparable performance to NEMHS, though the data set is limited. The department operates under a **24/7 staffing model**, with one EMS provider on duty at all times and **per diem staff** supplementing coverage.

Comparison of Response Time Reliability

Analysis of response time data from NEMHS and Rockport Fire shows **little difference in reliability**, with both entities capable of meeting response time expectations. However, Rockport Fire's **limited EMS experience** and smaller operational scale may introduce challenges as it transitions to a full ambulance service.

III. Regional Impact of Transition

A. Challenges for NEMHS

Discontinuing Rockport's contract removes a source of **patient transport revenue** and municipal subsidies, potentially impacting NEMHS's ability to maintain services in other contract towns, including **Camden, Hope, and Lincolnville**. NEMHS's leadership, with over **20 years of experience**, has been integral to maintaining EMS stability in the region.

B. Mutual Aid and Regional Coordination

Using **queuing theory calculations**, it is expected that Rockport will continue to rely on **mutual aid for simultaneous calls**, particularly during periods when its ambulance is already tasked with another emergency. For example, in 2023, Rockport required mutual aid for **10 incidents**, demonstrating the importance of maintaining **strong mutual aid agreements**.

Table 1 Queuing Theory Calculations

Optimal Planning of Ambulances					
https://www.few.vu.nl/~mei/Erlang%20Calculator	ambulances.html			24 Hours	Peak Hours
Rockport			Average number of calls per hour	0.0650	0.0869
Average Number of EMS Emergent Responses per Year	569		Average busy time per incident (in hours)	0.75	0.75
Average Calls per Hour	0.0650		Number of ambulances	1	1
Weighted Annual Calls during Peak 15 Hours	476				
Average Calls per Hour Peak Hours	0.0869		Busy probability (according to the Erlang formula)	0.046	0.061
			Average number of blocked calls per hour	0.003	0.005
			Predicted number of blocked calls per year	26.5	29.1

C. Broader Regional Impacts

Introducing Rockport's ambulance service increases EMS capacity in Knox County, potentially benefiting the region. However, the **fragmentation of EMS resources** could lead to inefficiencies if mutual aid relationships are not preserved. Collaborative planning is essential to balance local and regional needs.

IV. Rockport Fire Department Readiness

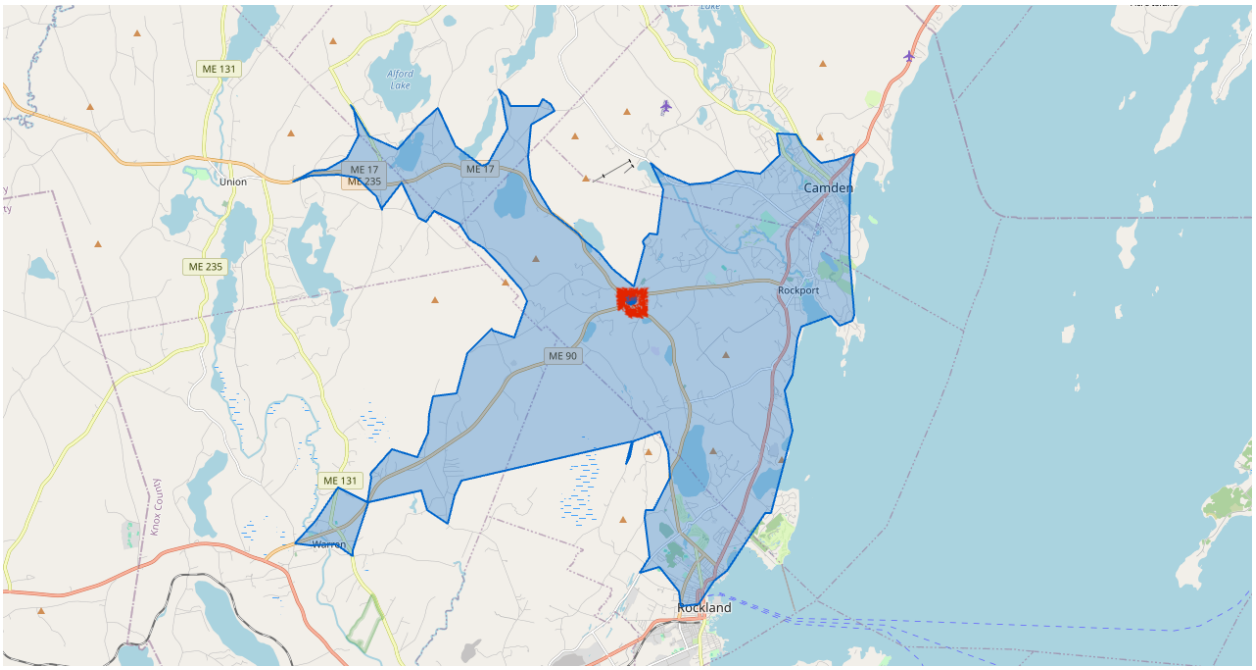
A. Staffing and Equipment

- **Staffing**:
  - Four **full-time Firefighter/EMTs** (three AEMTs and one EMT).
  - Four **paramedics**, including two with prior leadership roles as EMS chiefs.
  - Twelve **per diem staff** and 27 **volunteers**, including 15 EVOC-certified drivers and 4 EMTs.
- **Equipment**:
  - **2006 Horton Ambulance**, with a **2025 Horton Ambulance** expected in February.
  - Advanced equipment includes **Zoll X Series Defibrillators**, **Stryker Power Load systems**, and a **Lucas CPR machine**.

B. New Fire Station

The completion of Rockport's new **Fire Station**, located at the **intersection of Rockland Street and West Street (Route 17 and Route 90 in West Rockport)**, by the end of this year marks a significant milestone for the town's EMS operations. The facility will serve as the operational base for Rockport EMS staff, accommodating **24/7 operations**, and providing **modern amenities**, improved **response capabilities**, and a **centralized location** for efficient deployment of EMS resources.

Table 2 New West Rockport Fire Station with 10 Drive Isochrone



C. Experience and Operational Challenges

While Rockport Fire has demonstrated **capability in first-response services**, managing a full-scale EMS division requires expertise in **billing, compliance, and logistics**. The new fire station will provide the necessary infrastructure to support these expanded operations, though addressing administrative gaps remains a critical priority.

V. Benefits of Transition

A. Improved Local Control

Transitioning to a municipal ambulance service ensures that Rockport can **prioritize its specific needs**, reducing dependence on external providers and adapting to future challenges.

B. Enhanced Resources

Adding Rockport's ambulance increases **EMS capacity** in Knox County, improving the town's ability to manage emergency response internally.

C. Long-Term Potential

The transition lays the groundwork for Rockport to serve as a **regional EMS leader**, potentially collaborating with neighboring towns to create a robust, municipal-based EMS system.

VI. Recommendations

1. **Capacity Building**:
   Invest in training for billing, compliance, and operational management to address administrative challenges.
2. **Mutual Aid Coordination**:
   Maintain strong agreements with NEMHS and neighboring towns to handle simultaneous calls and ensure adequate coverage.
3. **Regional Collaboration**:
   Facilitate discussions with Knox County towns and NEMHS to balance EMS resources and support regional stability.
4. **Performance Monitoring**:
   Develop benchmarks for response times, transport rates, and patient outcomes to track and improve the new service.

VII. Conclusion

Rockport's transition to a municipal ambulance service represents a **bold step** toward improving **EMS reliability** and **local control**. However, the **relative inexperience of Rockport Fire**, the potential **financial and operational impacts on NEMHS**, and the continued **need for mutual aid** highlight the importance of **careful planning and regional coordination**. By addressing these challenges, Rockport can establish a **strong foundation for its EMS operations** while contributing to a **sustainable and resilient EMS system** for Knox County.

Consultancy Report Requirements:

1. **Changing ambulance services is in the best interest of residents**:
   Transitioning ensures **local control** and addresses Rockport's priorities, reflecting the town's substantial investment of time and financial resources toward establishing municipal EMS services.
2. **Maintaining/improving patient care quality**:
   With highly trained staff, advanced equipment, and proper oversight, Rockport Fire is positioned to maintain a standard of care that matches NEMHS's performance.
3. **Improving system efficiencies and use of resources**:
   A municipal service allows Rockport to directly manage EMS resources, improving deployment efficiency while minimizing reliance on outside agencies.
4. **Maintaining/enhancing response efficiencies**:
   Analysis of response times demonstrates that Rockport can meet or mirror NEMHS's reliability, particularly with robust operational protocols and mutual aid agreements.

By focusing on **capacity building**, **mutual aid agreements**, and **regional collaboration**, Rockport can balance local control with regional cooperation, ensuring sustainable, high-quality EMS services.

ROCKPORT FIRE DEPARTMENT
POB 142, 85 Main St. Rockport, ME 04856 (207) 236-4437

Rockport Fire & EMS Department
EMS QA/QI Policy

MISSION STATEMENT

It is the mission of Rockport Fire & EMS to provide the highest quality prehospital medical care to the citizens of Rockport and surrounding communities whenever the need arises. In an effort to ensure this high level quality of care, this policy will define the characteristics under which that care will be provided, reviewed, maintained and enhanced. Continuing education, call monitoring and establishing a standard of best practices will be a distinct priority.

STRUCTURE

The Fire Chief will designate the Quality Assurance Board (QA Board) which will oversee all functions of Quality Assurance. The QA Board will consist of the Fire Chief, the Service Medical Director, EMS Supervisor, QA Manager, and a minimum of one other licensed provider designated by the Chief as staffing allows. Designees will automatically recuse themselves from reviewing any reports concerning calls with which they were directly involved. Any requests from Maine Emergency Medical Services (MEMS), hospitals or other providers will be directed to the Duty Officer who will coordinate an open, honest and prompt response to the inquirer, within the limits of the law. All plans of action regarding remedial training will be developed by the QA Board. Should the findings of the QA Board require discipline of the member, such discipline shall be administered by the Chief with advice and counsel of the QA Board. The QA manager shall be responsible for monitoring all department members' reports for accuracy, completeness, assessment and diagnosis, and appropriate care and protocol use. The Chief of Department will attend any requested QA meetings as needed, for specific matters requiring administrative involvement.

DOCUMENTATION AND REPORT FILING

In furtherance of the goal of the Rockport Fire & EMS to provide the highest quality prehospital EMS care, it is recognized that high quality documentation is paramount. Through commitment to a thorough and critical self-review process, the department has established and will ensure through a continuous QA process the following documentations standards.

Standards for Patient Care Reports for Patients Transported by Rockport Fire & EMS

Required Maine Emergency Fire Incident Reporting System (MEFIRS) fields that are indicated by a red border to achieve as close to 100% validation as possible. The following is a guide for the majority of the MEFIRS Report content.

1. Incident Times – Incident times will be completed from the official KRCC Log.
2. Mileage- "Beginning" and "At Scene" odometer box must read "0", "Patient Destination" and "Ending" odometer must read the mileage from scene to hospital
3. CAD/Dispatch –
    a. Incident information
        i. Incident Number
            1. Add Incident # (For multiple patients remember to assign specific number, e.g. **** - 01, -02, etc)
        ii. Incident/Patient Disposition- choose appropriate
        iii. Level of Service Provided- **only** choose "ALS", "BLS" or "None Provided"
    b. Dispatch Information
        i. Complaint Reported by Dispatch- choose appropriate that fits what dispatch sent you for
        ii. Dispatch Priority- choose level of dispatch code
        iii. EMD Performed- choose appropriate
    c. Unit Information-
        i. EMS Vehicle License Number- will auto-fill when "EMS Unit Call Sign" is chosen
        ii. Vehicle Dispatch Location- Choose "Rockport EMS"
        iii. EMS Unit Call Sign- choose your appropriate apparatus
        iv. Primary Role of Unit- choose either " Ground Transport", "Non-Transport Rescue" or "Intercept"
        v. Level of Care of This Unit- "AEMT", "Paramedic", or "ALS Intercept"
        vi. Unit Type- choose "ALS" box
        vii. First EMS Unit on-scene- select appropriate answer box
    d. Response Info-
        i. Type of Service Requested- choose "911 Response (Scene)", "Intercept", "Mutual Aid", or "Standby"
        ii. Response Urgency- "immediate"
        iii. Response Mode to Scene- choose appropriate box
        iv. Type of Response Delay- use if needed
    e. Incident Address-
        i. Incident Facility or Location- "Knox Center", "Woodlands of Rockport" "Methodist Conference Home"
        ii. Incident Street Address- Where patient is found, not where injury may have occurred
    f. Crew Info-
        i. Crew Members- Select all crew associated with the call, and assign each person AT LEAST one role. Remember one "Driver/Pilot-

Transport" must be assigned to each patient report transported to the hospital
   ii. EMS Shift- pick the correct shift
   iii. Exposures- you MUST fill out all appropriate PPE that was worn by EACH person on-scene
4. On Scene-
   a. Scene Information-
      i. Incident Location Type- Choose appropriate
      ii. Number of Patients at Scene- Choose appropriate
   b. Patient Condition-
      i. Possible Injury- Choose appropriate
      ii. Cardiac Arrest- **MUST** choose appropriate option
   c. Other Agencies On Scene-
      i. Received from Agency ID- for mutual aid, intercept options
5. Patient Information-
   a. Patient Lookup
      i. Find a Repeat Patient- use this tool first, consider spelling may change results. DOB must match, if duplicate patients found, please let QA person know
   b. Name, Age, and Weight-
      i. First name
      ii. Middle Initial
      iii. Last name- please double check spelling if possible against hospital sticker
      iv. Suffix- if appropriate
      v. Gender
      vi. Date of Birth- also double check if possible against hospital sticker
      vii. Estimated Body Weight
   c. Patients Address
      i. "Same as Incident address" may not always apply. Use PO Box if mailing address is different
      ii. Patients Phone Numbers- Is a required box, however if you do not have a phone number, click on the box, then move on. It will turn off the red required part
   d. Closest Relative- Use this section for minor patients, to enter a parent or guardians information
6. Patient Medical History-
   a. Past Patient History
      i. Medical/Surgical History- enter all appropriate given history. Double check repeat patient history for accuracy. Choose "other medical condition, not listed" and enter in fill-in box below if needed
      ii. Medical History Obtained From- Choose appropriate
      iii. Advance Directives- If known
      iv. Patient Practitioners- Enter if known
      v. Pregnancy- choose appropriate
      vi. Other Past Medical History- Enter any history given that did not have an option in drop-down box above

b. Patient Medications
    i. Current Medication- please enter ALL medications the patient is currently taking. IF using "repeat patient" function, please double check medications listed, and edit as needed.
c. Allergies
    i. Environmental Allergies- use if appropriate
    ii. Medication Allergies- use if appropriate

7. Vitals/Treatments/Labs
    a. Vitals- you must enter AT LEAST one set of vital signs per patient. IF medications were administered by you (the provider) ie-nitro, there **MUST BE AT LEAST** one set of vital signs **BEFORE** and **AFTER** each dose given. If uploading vital signs from Zoll Cloud, make sure to double check for accuracy
    b. Procedures Performed- Enter each procedure in this section, ie- cervical collar application, blood glucose, IV access, splinting. Please DELETE any uploaded ECG procedures if using Zoll cloud (they are listed in ECG section)
    c. Medication(s) given- list ANY medications you as the provider have given, including normal saline, or oxygen
    d. Assessments- use if pertinent to the call. ie- a trauma patient should have multiple assessments documented, or a pupil assessment on opiate overdose
    e. ECG- Enter manually, or upload from Zoll Cloud. If uploading information, make sure to address each "red" box requiring more info
    f. STEMI- N/A
    g. Airway- Use if an advanced airway has been placed
    h. Labs- N/A
8. Patient Assessment
    a. Patient Complaint
        i. Complaints- list the patient complaint and/or reason for transport in this section.
        ii. Chief Complaint Anatomic Location- choose appropriate
        iii. Chief Complaint Organ System- choose appropriate
    b. Symptoms-
        i. Date/Time of symptom Onset- use if known, or choose "not applicable"
        ii. Date/Time Last Known Well- use if known, **ESPECIALLY for Stroke Patients,** or choose "not applicable", or "unable to complete"
        iii. Primary Symptom- choose closest appropriate answer
        iv. Initial Patient Acuity- choose appropriate
        v. Alcohol/Drug Use Indicators- MUST choose one option if applicable, or choose "not applicable", or "none reported" from right hand box
    c. Protocols- N/A
9. Transport/Destination Information-
    a. Transport Information-
        i. Number of Patients Transported in this EMS unit- enter "1"

ii. Transport Mode From Scene- choose Appropriate
iii. EMS Transport Method- choose "Ground Ambulance"
iv. How Patient Was Moved to Ambulance- choose all that apply
v. Position of Patient During Transport- choose appropriate
vi. How Patient Was Transported From Ambulance- choose appropriate
vii. Type of Transport Delay- use if needed

b. Destination Info-
   i. Destination Transferred To- select "Pen Bay"
   ii. Reason for Choosing Destination- select "closest facility", "Diversion" or "Patient/Family Choice"
   iii. Condition of Patient at Destination- choose appropriate
c. Destination Address- should auto-fill from previous page

10. Narrative-
   a. Provider's Primary Impression- Choose closest fitting option. There MUST be a listed "primary impression" chosen for ALL transported patients. "Adult- no findings or complaints" or "Child- No Findings/Complaints" will only be acceptable on a refusal or when no other option is able to be used.
   b. Provider's Secondary Impressions- choose appropriate if needed
   c. Transfer Reason Category-N/A
   d. Interfacility Transfer Working Diagnosis- N/A
   e. Patient Care Report Narrative-
      i. Members shall utilize a common or recognized medical documentation narrative form to complete their reports. This can include but is not limited to, SOAP, CHART, HPI/PMHx/PE/Provider Impression/Tx, etc. formats.
      ii. The following information is required and shall be included in each report narrative:
      History of Present Illness – A brief but thorough description that provides the reader with a clear picture as to any events or actions by the patient or others that directly or indirectly precipitated the need for prehospital emergency services.
      Pertinent Past Medical History – A brief recap of the patient's pertinent medical history. While this is covered in the History/Assessment page, many receiving physicians have stated their best information comes from the narrative page. Therefore, RFD written reports will accommodate that by providing a brief, efficient snapshot of the patient's history.
      Physical Exam – This portion of the report should start with a brief description of how the patient presents to EMS including all pertinent positives and negatives discovered during the assessment/exam and be concluded with a brief synopsis of all patient care provided as well as positive or negative responses to those treatments. If you choose to use Conscious/Alert/Oriented as your mental status scale, CAOx4 is the rating that will be used as completely alert and oriented.

Provider Impression – The person writing the report should also indicate a suspected problem that EMS provided care/transport for. When choosing your wording, be sure the care provided coincides with your suspected problem. While this may be omitted as long as the provider feels it was adequately described in the drop down box at the top of the page, it is still recommended to clarify ambiguous menu options.

Treatment – While it is usually covered in the physical exam section, the provider should provide a line on all treatment provided as a brief synopsis that is easily located for the receiving facility staff.

When your narrative is complete, you are required per this Standard to utilize the spell check option.

f. Crew Member Completing this Report- Should Auto-fill with your name
g. Review Requested-N/A
h. RFD Mutual Aid Questions- to be filled out if RFD GAVE Mutual Aid (not received)
    i. Did Rockport Fire & EMS provide Mutual Aid for EMS- "yes" or "no"
    ii. Mutual Aid: What Type of service was requested- choose appropriate
    iii. If provided, which EMS Service received Mutual Aid-

11. Cardiac Arrest – Must be completed in all cardiac arrest responses
12. Billing Info – N/A
13. Signatures –
    a. Signatures- must obtain or sign any appropriate signatures, depending on nature of the incident
        i. "Patient Signatures" section- required for all transported patients that are able to sign
        ii. "EMS Primary Care Provider Signature" section- required for all reports
        iii. "Patient Representative Signatures" section if needed ie-minor requiring parent signature, family member signature
        iv. "Healthcare Facility Provider Signatures" if report given to ED RN or MD for a transported patient
        v. "Patient Refusal of Care Signatures" section- if patient is a refusal
        vi. "Witness of Patient Refusal of Care Signature" section- if obtaining a refusal
14. AMA-Against Medical Advice-
    a. Patient refusal-
        i. "Patient Reason for Refusal" select one box
        ii. "AMA Type"- select one box
        iii. "Disposition Instructions Provided:" select all that apply
        iv. "AMA Initial Disposition"- select all that apply
        v. "AMA Interventions"- select one
    b. Patient Plan-
        i. "Patient Alternative Plan" select one box

ii. "Is Patient oriented to person, place, or time & event:" select appropriate answer
iii. "Is Patient Unimpaired by drugs or alcohol:" select appropriate answer
iv. "Is Patient competent to refuse care:" select appropriate answer
v. "Has Patient been advised that 911 ca be reassessed:" select appropriate answer
vi. "Have the risks and complications of refusal been discussed:" select appropriate answer
vii. "Is the patient 18 years of age or emancipated:" select appropriate answer
viii. "No medical care or only BLS care rendered:" select appropriate answer
ix. "AMA Contact Medical Direction Facility" only if OLMC was contacted

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Standards for Patient Care Reports for Patients Who Have Appropriately Refused Care/Transport by Rockport Fire & EMS

Reports entered into the MEFIRS system for patient refusals will, as expected, differ slightly. The selection of the "Patient Refuses Treatment" or "Patient Refuses Transport" option will automatically close some fields. All other fields that remain open shall be completed to the standard of a patient who is transported. Narratives should be just as in depth for patients that refuse transport. Significant attention should be paid to including information regarding description of the scene, conversations between providers/patients/OLMC and the specific dangers of refusing treatment and/or transport. The "patient refusal" and "patient plan" sections of your MEFIRS report will be filled out, along with proper signatures obtained.

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Standards for Patient Care Reports for Incidents Which Required No Patient Care/Transport by Rockport Fire & EMS

MEFIRS reports for calls that meet the stringent criteria to warrant no patient care or transport will be minimal. These incidents will be limited to Accidental/Malfunctioning medical alarms and third party calls by persons with no immediate knowledge of the scene (Example: passerby sees a man sitting on the curb and calls 911 thinking he may be in distress). These calls will be clearly identified on the radio via high band as an audio record along with specific documentation in the MEFIRS report. In addition to information for standard MEFIRS reporting, providers shall gather and enter into the MEFIRS report such information as: the type of malfunction or cause for false activation, the troubleshooting

steps taken (resetting unit, unplugging, etc), the name of the contact at the alarm company (if applicable), whether the medical alarm was in service when EMS personnel left the scene and any other corrective/assisting actions taken by Rockport Fire & EMS.

Completion and Filing of Reports

Once the care of the patient has been transferred to the hospital, providers need to complete the following steps regarding the filing of reports.

1. Complete RFD Patient Care Handoff Form with signature and printed name from both the primary RFD provider and the receiving RN/MD. Leave a copy with hospital staff.
2. Gather all signatures needed to complete "signatures" section on MEFIRS report depending on call type
3. Complete MEFIRS report immediately upon returning to quarters and before continuing with other non-emergency duties.
4. Shred all dispatch logs, extra notes, and any other paperwork not requiring filing that contain confidential patient information.

REVIEW

One hundred percent (100%) of EMS runs entered into MEFIRS by members of Rockport Fire & EMS will be reviewed. Each run report will be reviewed for completeness, accuracy, response time, treatment provided, medication given, rhythm recognition, if necessary, compliance with MEMS protocols, and consistency with Rockport Fire & EMS reporting standards. Any incomplete reports will be returned to the primary crew member for completion. Any reports that indicate questionable patient care will be flagged with a Critical Call Review Form and placed in the Critical Call review form log.

Any run noted within the QA Review process to be of a High Acuity/Low Volume (Multitrauma, Cardiac Arrest, Pediatric Calls, etc) type or an Adverse/Concern Event type that are logged and reviewed will be further reviewed by a second provider if needed. If a report with provider reviews still remains in question regarding events or care given, it will then be forwarded to the QA Board for review. Such review may result in required remedial training or some form of disciplinary action.

Review of these runs will identify incidents and the level of care provided with the following definitions:

INCIDENTS

High Acuity/Low Volume: Any event that occurs rarely and involves a high potential for untoward outcome. This probability can come from any number of factors including but not limited to provider experience, exposure to similar events, recent training on similar topics and expected complications of event due to pathophysiology of illness/injury.

Adverse/Concern Events: Any action or inaction on the part of the responsible provider that caused actual or potential harm to a patient. This can include but is not limited to medication errors, improper or off protocol treatment choices, choice not to provide a particular medication or treatment based in protocol or established best practice.

Protocol: Any protocol established by the Maine EMS Medical Direction and Practice Board or a Rockport Fire & EMS service-defined protocol that is based in contemporary best practice and evidence based medicine that is approved by the service medical director.

Off Protocol Event: Any skill, intervention, medication or other care that is used for a subset of patient that it is not specifically intended but may be beneficial for. Practice of this nature should be rare in occurrence and used in conjunction with on-line medical control (OLMC) approval. Approval at the time is not carte blanche permission to repeat and must be reviewed if used to ensure care was done with the best interest of the patient in mind and had no untoward outcomes.

LEVEL OF CARE

Appropriate: Care provided by EMS crew that is grounded in current MEMS protocol, established best practice/evidence based medicine or is (in the rare circumstance) performed in an off protocol manner with OLMC approval that is the proper course of action for a **specific patient.**

Acceptable: Care provided by EMS crew that, while grounded in current MEMS protocol or established best practice/evidence based medicine, is not the typical first line care for a particular subset of patient. Care of this nature, while not optimal per protocol, results in a positive outcome for the patient *and absolutely no* untoward effects noted in follow up with receiving facility.

Sub-Optimal: Care provided by EMS crew that is not completely grounded in current MEMS protocol, established best practice/evidence based medicine or is not the typical first line care for a particular subset of patient. Care of this nature is not optimal or the expected first choice for similarly experienced and trained providers. Care of this nature, while not resulting in a negative outcome for the patient in the field results in no positive improvement or is shown to have an untoward effect for the patient noted in follow up with the receiving facility.

Substandard: Care that is inappropriate and results in any (minor or major) untoward effect on the patient upon review, either in the field or noted in a follow up with the receiving facility.

REMEDIATION AND FOLLOW-UP

Should a run that generates a Critical Call Review Form identify care that is either Sub-Optimal or Substandard, the QA Board and/or Chief Officer will decide upon any remediation and follow-up. Remediation should be just and aimed at helping the EMS provider better perform his/her duties. Documentation of the recommended corrective

action, defined goals and a follow up plan with time targets will be entered in the Critical Call Review Form, signed by the Primary Provider, Primary Reviewer and Chief of Department. All disciplinary actions will be in conjunction with the QA Board and the Fire Chief in accordance with the Personnel Policy for the City of Rockport and any collective bargaining agreements which may be in effect.

TRAINING

In keeping with the Mission Statement of the Rockport Fire & EMS QA Policy, it should be understood that training is of the utmost importance. All EMS providers are strongly urged to attend all available, applicable training with those individuals who respond to fewer calls needing to make a special effort to attend additional training in order to maintain skill levels (the training paradox). EMS is an ever-changing field and in order to provide the citizens of Rockport, Owls Head and the surrounding communities with quality care, we must remain prepared to meet these challenges.

In the event that an insufficient number of calls and skills have been completed or performed by a provider, the QA Board will request that remediation or training assignments be administered to those individuals lacking in call volume and/or skill performance. This issue will be considered on a case by case basis at the discretion of the QA Board and Chief of Department.

QA CHECK SHEET LIST

COMPLETENESS

Incident Info

1) Response Times
2) First Responder Agencies (if applicable)
3) Response Information
4) Personnel
5) Incident Information
6) Location Type
7) Barriers to Patient care

Call Info

1) Destination Information
2) Destination Type
3) Destination Determination
4) Response Request
5) Primary Role of Unit
6) Response Disposition
7) Transfer of Patient Care (if applicable)
8) Response Mode to the Scene
9) Response Mode from the Scene

10) Vehicle Type
11) Dispatch Delay
12) Response Delay
13) Scene Delay
14) Transport Delay
15) Turnaround Delay

Demographic

1) Name
2) Gender
3) DOB
4) Phone Number
5) Address
6) Patient approximate weight

History

1) Patient Condition
2) Past Medical History
3) Allergies
4) Medications

Assessment

1) If the patient assessment is not done in this part, it must be written in the narrative

Vitals/Treatment

1) Make sure all applicable information is filled in.

Narrative

1) Provider Impression
2) Patient Transport/Positioning
3) Safety Equipment (if applicable)
4) Vehicular Information (if applicable)
5) Service Defined Questions (if applicable)
6) Narrative

PATIENT CARE

General

1) Was the response time within acceptable limits?
2) Was the on scene time within acceptable limits?
3) Was the transport mode appropriate for the suspected problem?

4) Was the appropriate personal protective equipment worn?

Assessment

1) Was a proper patient assessment conducted?
2) Were multiple sets of vitals taken?
3) Were vitals taken complete?
4) Were lung sounds taken?
5) Do the signs, symptoms and information gathered during patient assessment lead to the suspected problem?
6) Are the signs, symptoms or information gathered contradicting the suspected problem?

Decision Making

1) Was the appropriate protocol selected for the suspected problem?
2) Was the protocol followed in order?
3) Was medical control required and/or contacted?

Cardiac Arrest Review Board

In keeping with providing the highest quality of prehospital medical care, a "Cardiac Arrest Review Board" will be established. Recognizing the amount we as providers can learn from each other is paramount, along with assuring our set high standards are maintained with each arrest. On a monthly basis a minimum of three paramedics previously assigned by the chief, will review each cardiac arrest report checking for completeness, accuracy, and to assure proper care given. Each arrest report will be added into the "critical call review book", with the board answering the following questions

1. Were the proper MEMS protocols followed?
2. Which Level of Performance does the care fall? "Appropriate", "Acceptable", "Sub-Optimal", or "Substandard"
3. Are the times correctly documented?
4. Was the rhythm correctly identified? And treated appropriately?
5. Were the correct medications administered? Are the times noted with the medications correct?
6. Do the medications given correctly match those listed in the narrative section?
7. Were the chosen procedures correct? Were they performed in a timely manner?
    a. IV/IO access obtained?
    b. Proper Airway secured with BIAD or ET?
    c. Was Capnography used (if BIAD or ET)?
8. Is the narrative in proper RFD format?
9. Is the narrative clear and concise with a good "painted picture"?
10. Was the rate of CPR within recommended guidelines?
11. Were pauses in CPR kept to a minimum?
12. Was ROSC obtained?

Treatment

1) Once selected was the protocol followed?
2) Were treatments provided appropriate for the selected problem?

Was the selected protocol completed prior to arrival at the medical facility

Rockport Fire & EMS

Prehospital Medication Agreement

This agreement (the "Agreement") made and effective this first day of July, 2024 by and between Penobscot Bay Medical Center, a Maine non-profit corporation with a principal place of business in Rockport, Maine (Hereinafter referred to as "Hospital"), and Rockport Fire/EMS Department (Hereinafter referred to as "EMS Service") shall be for the purpose of establishing a system for the provision, monitoring, and restocking of medications which are utilized by the EMS Service to improve quality of patient care and minimize duplication of services.

BACKGROUND

The Maine Legislature passed the Maine Emergency Medical Services Act of 1982 (the "Act") for the purpose of creating a statewide emergency medical services system to ensure the provision of comprehensive emergency medical services to individuals residing in the state of Maine. The Act established Maine Emergency Medical Services ("Maine EMS") as a bureau within the Department of Public Safety. Maine EMS is comprised of six regions. The EMS Service operates within Maine EMS Region 6.

The Emergency Medical Services Board (the "Board") licenses ambulance services in the state of Maine to carry medications for the delivery of patient care consistent with Maine EMS Prehospital Treatment Protocols (the "Maine EMS Treatment Protocols"). Each ambulance service so licensed is required to use as its source of medications a single hospital that has a pharmacy, several hospitals with either individual or central supply points, or another source approved by the Board.

Rockport Fire/EMS has adopted a policy governing the provision of medications to the EMS Service, a copy of which is attached hereto and incorporated herein as Attachment A (the "Policy"). The Federal Drug Enforcement Agency (DEA) requires that each EMS ambulance service that carries controlled medications have a signed agreement in place with the facility providing the controlled medications which incorporate the Policy adopted by that EMS ambulance service, and details the system for transfer and storage of the medications, inventory and record keeping and audit of the system.

EMS Service is a licensed ambulance service that provides emergency transports to Hospital and is authorized under Maine law to administer drugs and medications.

The Hospital operates a licensed Hospital in Rockport, Maine (hereinafter "Hospital") with a fully integrated, on-site pharmacy. The Hospital has agreed to be a source of medications for the EMS Service as described more fully in this Agreement.

Now, therefore, in consideration of the mutual covenants contained herein, the parties hereto agree as follows:

1. Limits of Participation: The Hospital agrees to participate with other hospitals receiving patients from the EMS Service in the maintenance of medications (including controlled and non-controlled medications) used by EMS personnel in transit to the receiving hospital. If indicated on Attachment B, the Hospital further agrees to serve as the EMS Service's "Primary Hospital" and provide the services of a Primary Hospital as described herein and in the Policy. The Hospital agrees to provide the EMS Service with controlled and non-controlled medications in accordance with the specific procedures outlined in the Policy and any hospital-specific requirements of which Hospital notifies the EMS Service ("Hospital Requirements"). Hospital Requirements as of the date of this Agreement are set forth on Attachment B. The Hospital shall not be required to provide medications to the EMS Service which are not included in the inventories contained within the EMS Policy, as the same may be amended from time to time.

2. Provision of Emergency Medical Treatment: Emergency medical treatment shall be rendered in accordance with the Maine Emergency Medical Services Act of 1982, 32 M.R.S.A. §81 et. seq., the Maine Emergency Medical Services System Rules promulgated pursuant thereto, and the Maine EMS treatment protocols.

3. Medication Provision, Monitoring, and Maintenance: The provision, monitoring and maintenance of medications placed in EMS Service units shall be carried out in accordance with the Policy, Maine EMS Rules, applicable EMS Service policies, and any Hospital Requirements. All non-controlled drugs and medications will be stored in a container or location that provides reasonable protection from both physical damage and temperature extremes. The EMS Service will maintain a log of non-controlled medications as required by Maine EMS rules. Controlled medications will continue to be stored in a container secured with a one-time, pharmacy-type numbered seal. This seal will be applied and recorded by an authorized representative of the hospital. The container will be labelled with the expiration date of the earliest expiring medication

4. Drug Box Use: It is understood by all parties that the medications will be accessed only by the EMS Service's personnel who are permitted by Maine EMS licensure to administer the drugs and medications contained within the drug box.

5. Controlled Drug Inventory: The Hospital shall be responsible for maintaining a perpetual inventory of all controlled substances dispensed by the Hospital to the EMS Service. The initial supply of

controlled substances is supplied by the Primary Hospital. EMS Service agrees to store them under special locked conditions with a perpetual periodic inventory and replacement as specified by the Policy. The initial supply provided by the Primary Hospital is set forth in Attachment B.

6. Warranty Exclusion: All medications supplied by the Hospital under this Agreement are provided "as is" and without warranty of any kind, either expressed or implied. Hospital agrees that it will follow best practices and will comply with the Policy and all applicable federal and state laws, rules and regulations in the preparation, storage and distribution of the medications.

7. Consideration: The Hospital will provide services with an initial supply of non-controlled medications in such quantity to supply each licensed vehicle and provide a reserve supply to be stored at the EMS Service base(s). Controlled medications will be replaced on a one-forone basis by exchanging the entire controlled substance box for a new box sealed by the pharmacy. The Hospital will continue to invoice the EMS Service at cost for the non-controlled medications used in the transport of a patient to the Hospital. If Hospital has agreed to serve as EMS Service's Primary Hospital, Hospital will replace medications that (a) break, expire or are used in no-transport situations or (b) are used in the transport of a patient to a hospital out of state or with which EMS Service otherwise has no restocking arrangement at no cost; provided that EMS Service agrees to maintain restocking arrangements with all hospitals to which it transports patients with any regularity. The EMS service shall return to the Primary Hospital all medications scheduled to expire 30 days prior to the expiration date for replacement

8. Record Keeping. For each patient transported to the Hospital where a controlled medication is used, EMS Service shall provide Hospital with a run report at the time of the controlled medication exchange. In addition, the parties will maintain records of all drugs restocked pursuant to the Agreement and the Regional Medication Policy for a minimum of five (5) years and will make such records available to the other party, to Maine EMS and to the Secretary of the United States Department of Health and Human Services promptly upon request.

9. Mutual Indemnity: The Hospital, its successors and assigns, agree to hold harmless and indemnify the EMS Service, its successors and assigns, from any claims, costs, liabilities, and expenses arising from or attributable to any acts or omissions of the servants or employees of the Hospital in performing its obligations under this Agreement. The EMS Service, its successors and assigns, agree to hold harmless and indemnify the Hospital, its successors and assigns, from any claims, costs, liabilities and expenses arising from or attributable to any acts or omissions of the servants or employees of the EMS Service in performing its obligations under this Agreement.

10. Insurance: Each party shall maintain a policy of professional liability insurance during the term of this Agreement in an amount sufficient to cover its obligations under this Agreement. In the

event a party's professional liability insurance coverage is on a claims-made basis, such party shall continue that coverage for at least thirty-six (36) months following termination or expiration of this Agreement, or obtain additional insurance in the same coverage amounts for claims brought after termination or expiration of this Agreement with respect to occurrences during the term of this Agreement.

11. Independent Contractor: It is understood and agreed between the parties hereto that the Hospital's participation in this Agreement and maintenance of medications shall not constitute a partnership or joint venture. Each party shall be responsible for providing its' own services as described herein and according to the aforementioned Policies.

12. Amendment: This agreement may be modified or amended by mutual assent of the parties hereto; any such modifications or amendment shall be attached to and become part of this Agreement.

13. Compliance with Policy and Applicable Laws: The terms of this Agreement and the actions of the parties pursuant hereto shall comply with the terms of the Policy and with all federal and state laws and regulations.

14. Periodic Review: Representatives of the EMS Service and the Hospital shall periodically review this Agreement at mutually agreed upon dates and times.

15. No Requirement to Refer. The Hospital's provision of medications hereunder is in no manner based upon or conditioned upon the volume or types of patients transported to Hospital. The EMS Service units may transport patients to any hospital or other entity providing emergency medical treatment consistent with professional medical judgment and the needs and wishes of the individual patients.

16. Access to Books and Records. If required by 42 U.S.C. 1395 x(v)(1)(I), each party agrees that until the expiration of four years after the furnishing of services pursuant to this Agreement, the parties shall make available, upon written request, to the Secretary of the United States Department of Health and Human Services ("the Secretary") or to the Comptroller General of the United States, or any of their duly authorized representatives, this Agreement, and any books, documents and records of each party that are necessary to certify the nature and extent of the costs.

17. Term: This Agreement will automatically renew on the yearly anniversary of the date originally signed, unless either party requests a change in terms and conditions or unless terminated in accordance with paragraph 18 below. A request to change the terms and conditions of this Agreement must be submitted, in writing, at least thirty (30) days prior to the anniversary of the current Agreement.

18. Termination: This Agreement may be terminated as follows: a. Either party may terminate this Agreement at any time by providing the other party with written notice of termination at least 60 days in advance of the effective date of termination. b. Either party may terminate this Agreement if the other party breaches a material term of this Agreement and/or the Policy. In such event, the non-breaching party shall provide written notice of termination to the breaching party, which notice shall specify the nature of the breach and afford the breaching party ten (10) days in which to cure the breach (the "Cure Period"). This Agreement shall automatically terminate at the end of the Cure Period if the breach has not been cured. c. Either party may terminate this Agreement at any time upon notice if the other party is listed by a federal or state agency as debarred, excluded or otherwise ineligible for participation in federally funded health care programs.

19. Entire Understanding. This Agreement, including the Policy, contains the entire understanding between the parties and supersedes all other agreements and understandings between the parties with respect to the subject matter hereof. Any changes to this Agreement must be made in writing and signed by both parties.

20. Governing Law. This Agreement shall be governed by and construed in accordance with the laws of the state of Maine.

21. Counterparts. This Agreement may be executed in counterparts, each of which shall be deemed to be an original, but all of which, taken together, shall constitute one and the same agreement.

By signing this prehospital medication agreement, the parties hereto are authorizing the on-duty EMS personnel of the EMS Service to act as authorized representatives of the hospital for the sole purpose of examining the contents of the drug box and applying the one-time, pharmacy type numbered seal. The opening for inspection and resealing with a numbered seal must be recorded in the EMS Service's drug box log. (Lack of signatures invalidates this section and requires that all drug boxes be brought into the hospital if they are opened and require resealing.)

Rockport Fire & EMS

IN WITNESS WHEREOF, the parties hereto have executed this Agreement on this the first day of September, 2024.

EMS Service Representative Signature

Corey S. Bonnevie

Printed Name

Hospital Pharmacy Rep. Signature

Tyson Thornton, VP of Operations

Printed Name

RFD Service Medical Director Signature

Stephen Skinner MD

Printed Name

Attachment "A"

EMS Service Medication Policy

Included Separately

Rockport Fire & EMS

Attachment B

Pen Bay Medical Center

(September 1st, 2024)

Designation of Primary Hospital:

The Hospital agrees to serve as EMS Service's Primary Hospital.

Initial Supply of Controlled Drugs (If Applicable): The doses listed below represent the GROSS TOTAL AMOUNT to be supplied by the Hospital at any one time. These totals will be dispensed in the individual sealed kits currently assigned by PBMC, with a total of (1) one kits assigned to Rockport Fire EMS.

***600 mcg* Fentanyl** ***20mg* Midazolam** ***500mg* Ketamine**

Tyson Thornton, VP of Operations

Hospital Representative Signature

Service Representative Signature

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The Courier-Gazette

Publication URL:
knox.villagesoup.com/

Publication City and State:
Rockland, ME

Publication County:
Knox

Notice Popular Keyword Category:

Notice Keywords:
Rockport Fire

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Notice File:	Notice Publish Date:
0522770.pdf	Thursday, October 17, 2024

Notice Content

PLEASE NOTE: *The following text was electronically converted from the PDF document above, and may not be 100% accurate. Because of this, please view the PDF for the most accurate information.*

TOWN OF ROCKPORT The Town of Rockport is applying to the Maine Board of Emergency Medical Services to license Rockport Fire Department as the Primary 9-1-1 transporting service for the Town of Rockport. Rockport Fire Department intends to operate at the EMT level, permitted to provide care at the Paramedic level, with a primary service area of the Town of Rockport, Maine. There is no change to the way the public will request emergency services; citizens should continue to call 911 for all emergencies. The public is invited to make comments regarding the proposed application. Comments must be received by the Board of Emergency Medical Services within thirty calendar days of the publication of this notice. Comments must be mailed to Maine EMS, 152 State House Station, Augusta, Maine 04333-0152

Web display limited to 1,000 characters. Please view the PDF for the complete Public Notice.

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Users

Search Name or Username | Go

Permission Group Permission Group...

Agency Status Active | Inactive | Both

Show in Run Form Yes | No | Both | Reset

State Certification Level Select an option

Agency Certification Level Select an option

Staff Member Yes | No | Both

System Status Active | Inactive | Both

Yes | No | Both

Show in Fire Run Form Yes | No | Both

Yes | No | Both

+ New From EMS

1 - 18 of 18

Last Name	First Name	Username	Position	Staff Member	Permission Group	Show In Run Form	Agency Status	Login Access	System Status	Last Login
Bonnevie	Corey	22210		Yes	Agency User	EMS	Active	Yes	Active	10/08/2024 23:14
Dearborn	Stephen	spdearjr9617		Yes	Agency User	EMS	Active	Yes	Active	10/08/2024 14:38
Dietter	John	15409		Yes	Agency User	EMS	Active	Yes	Active	10/07/2024 22:43
Jacob	Kaitlin	kjacob		Yes	Agency User	EMS	Active	Yes	Active	10/09/2024 05:50
Lavoie	Art	art.lavoie		Yes	FMO Administrator	No	Active	Yes	Active	09/29/2024 10:39
Leo	Jamie	11589		Yes	Agency User (CP)	EMS	Active	Yes	Active	10/06/2024 10:53
Long	Drew	drewlong123		Yes	Agency User (CP)	EMS	Active	Yes	Active	10/09/2024 04:19
Lowe	Andrew	andycapp236		Yes	Agency User	EMS	Active	Yes	Active	05/19/2024 13:47
McAllister	Mark	17682		Yes	Agency Medical Director	EMS	Active	Yes	Active	
Merrifield	Eben	EbenMerrifield		Yes	Agency User	EMS	Active	Yes	Active	10/08/2024 23:06
Moore	Joseph	17095		Yes	Fire/EMS Agency Admin	EMS	Active	Yes	Active	10/09/2024 14:01
Nizolek	Ryan	rnizolek		Yes	Agency User	EMS	Active	Yes	Active	10/09/2024 12:20
Parent	Jennifer	Jenafar		Yes	Agency User	EMS	Active	Yes	Active	
Peasley	Jason	jpeasley		Yes	Fire/EMS Agency Admin	EMS	Active	Yes	Active	05/14/2020 12:06
Polky	Robert	24655		Yes	Agency User	EMS	Active	Yes	Active	01/23/2020 17:01
Pritchette	Corie	LibertyTruck99		Yes	Agency User	EMS	Active	Yes	Active	10/09/2024 09:25
Root	Michael	mroot20897		Yes	Agency User (CP)	EMS	Active	Yes	Active	10/07/2024 13:58
Southworth	Ryan	RyanSouthworth		Yes	Agency User	EMS	Active	Yes	Active	10/09/2024 08:56

Public Notice

The Town of Rockport is applying to the Maine Board of Emergency Medical Services to license Rockport Fire Department as a the Primary 9-1-1 transporting service for the Town of Rockport. Rockport Fire Department intends to operate at the EMT level, permitted to provide care at the Paramedic level, with a primary service area of the Town of Rockport, Maine. There is no change to the way the public will request emergency services; citizens should continue to call 911 for all emergencies. The public is invited to make comment regarding the proposed application. Comments must be received by the Board of Emergency Medical Services within 30 calendar days of the publication of this notice. Comments must be mailed to Maine EMS, 152 State House Station, Augusta, Maine 04333-0152

Post 10/10/24

ROCKPORT FIRE DEPARTMENT
POB 142, 85 Main St. Rockport, ME 04856 (207) 236-4437

Rockport Fire/EMS
Medical Director Job Description

Rockport Fire/EMS is a fire based, community focused emergency medical service provider operating at the Emergency Medical Technician Level (EMT) level. It's primary service area is the Town of Rockport. The scope of this agreement shall include all EMS operations conducted by the Town of Rockport fire department, up to and including any increase in permit level or transition to a transporting EMS service.

The major responsibilities of the Service Medical Director (SMD) will be to support administrative level functions including QA/QI oversight, service level training support and equipment procurement. As the service grows, develops and enhances its capabilities to serve the community, this position may grow in responsibility and expand in its scope and responsibility.

Position Requirements

I. Training Desired

1. Currently practicing Emergency Physician (Board-Certified Preferred)

2. Either completed, or planning to complete within one year, standardized training (such as through NAEMSP) course for EMS Medical Directors.

3. Complete the Maine EMS On Line Base Medical Control Program within one year of it becoming available.

II. Experience

1. Familiarity with the design and operation of EMS systems.

2. Passion for prehospital emergency care. Experience in prehospital emergency care of the acutely ill or injured patient desired.

3. Routine participation in base-station radio control of prehospital emergency units.

4. Routine active participation in emergency department management of the acutely ill or injured patient.

5. Active involvement in the education and training of prehospital personnel

6. Active involvement in the medical audit, review, and critique of prehospital personnel.

7. Participation in the administrative and legislative processes affecting the regional and state EMS systems.

III. Expectations, Roles, and Responsibilities

1. Ability to interact with others in a tactful and respectful fashion.

2. If in decision-making there is a potential conflict of interest because of the regional medical director's hospital affiliation, the regional medical director will withdraw from the decision-making, which will be the responsibility of the other local medical directors.

3. Attend MDPB meetings or review notes and matters of interest monthly via minutes provided by MEMS

4. Act as liaison with the local medical directors regarding protocol development and implementation, as well as other regional medical control issues.

5. Review, approve, and sign EMS service licenses both new and re-newal, for compliance with regional QI program.

6. Review personnel licenses and personnel issues such as QI or those requiring discipline upon request by regional coordinator or regional QI Coordinator.

IV. Term of Service

1. This position shall be hired by the Town Manager of Rockport, at the recommendation of the fire chief

2. The SMD contract will be a one year term of service that is updated annually.

3. 60 days prior to expiration of contract, both parties will communicate to determine if the provider wishes to continue in the role. This will allow time in good faith for the town to pursue a new candidate if the provider does not wish to continue in that role or negotiate the terms of the agreement.

4. The SMD can end the term of service before the term expires by giving a 60 day written notice.

5. Compensation: The Town of Rockport agrees to pay an annual stipend for the responsibilities of the SMD. Along with financial reimbursement for this role, the Town of Rockport shall provide legal support and coverage commensurate with all the duties and potential liabilities related to this role.

This agreement, entered into by the parties identified below and delineated by the terms above, stipulates the services expected and compensation provided for the Town of Rockport for the Service Medical Director.

The Town of Rockport agrees to provide all appropriate logistic, legal and clerical support commonly commensurate with this position as approved and required by state law. Any change to the terms of this contract will require proper notification of all parties involved.

John Duke, Rockport Town Manager — Date: 10/7/24

Mark McAllister, MD — Date: 10/7/24

Town of Rockport, Maine

Town Manager's Office
Town Office
101 Main Street
Rockport, Maine 04856
Telephone: 207-236-0806 x3
Fax: 207-230-0112

Jonathan Duke, Town Manager
Email: jduke@rockportmaine.gov

Diane Hamilton, Executive Assistant and General Assistance Administrator
Email: dhamilton@rockportmaine.gov

Emergency Medical Town Medical Director Contract

This Agreement ("Agreement") is entered into by the **Town of Rockport** (hereafter referred to as "Town") and Dr. Stephen Skinner (hereafter referred to as "Medical Director").

This Agreement will become effective on the date it is signed and shall remain in effect for a period of twelve (12) months. It will automatically renew for successive one (1) year periods on the anniversary date of the Agreement unless terminated by either Party. This Agreement may be terminated by either Party upon written notice delivered by certified mail at least sixty (60) days prior to the intended date of termination. The Agreement may be modified by the joint written agreement signed by both parties at any time.

The Medical Director is an employee of the Town, working in the Fire Department, and providing professional services to the Town. The Medical Director will not receive benefits from the Town other than pay as set forth in this Agreement.

a. The Medical Director will not subcontract any portions of the services to be performed under this Agreement without the prior written approval of the Town, approval of which will not be unreasonably withheld.

b. Medical malpractice insurance should be provided and maintained by the Medical Director.

Duties: The Medical Director agrees to perform the following services (in his absence, another physician mutually agreeable to Medical Director and Town shall provide those services):

1) Serve as the Medical Director for the Town pursuant to all applicable state laws and regulations.
2) Complete any MEMS required educational sessions for Medical Directors.
3) Assist in the development, revision and implementation of protocols for all levels of EMS providers and review of protocols at least annually through the Maine EMS protocol development and revision mechanism.
4) Review and approve the training standards of the Town, and review and approve continuing education and assist in the training of personnel as necessary.

5) Assist in the development of a Total Quality Management program for the Town to be conducted by designated Town QA/QI personnel under the supervision of the Medical Director to include:
    a) Data collection.
    b) Ongoing evaluation of patient care by thorough in-field observation and retrospective chart review on site evaluation.
    c) Investigation and resolution of medically related complaints.
    d) Suggesting remedial, corrective or disciplinary actions as appropriate.
    e) Development of a written medical incident review process, including procedures and potential disciplinary actions.
6) Regular review of system compliance with relevant federal, state, and local laws and regulations.
7) As applicable, review and recommend medical standards for dispatch procedures to ensure appropriate pre-arrival instructions are given and the appropriate EMS response unit (s) are dispatched to both the medical emergency scene and inter-facility transports.
8) Provide liaison activities between the Town and the following agencies or Town (if applicable) as outlined in Schedule A, which is incorporated into this Agreement.
9) Provide semi-annual written reports to the Fire Chief on EMS Medical Director activities.
10) Develop and present as directed by the Fire Chief.
11) Assist in program development, identifying and obtaining new resources and writing grant proposals to the extent reasonable in time and scope.
12) Represent Town on regional councils and boards as outlined in Schedule A.
13) Be reasonably available to personnel designated by the Fire Chief regarding patient care matters that arise during patient encounters as outlined in Schedule A.
14) The Medical Director will comply with the following laws when and while receiving, storing, processing, transmitting or otherwise dealing with any personally identifiable health information ("Protected Health Information" or "PHI") in any format or medium: the Health Insurance Portability and Accountability Act of 1996 ("HIPPA"), the Health Information Technology for Economics and Clinical Health Act ("HITECH"), and any regulations issued pursuant thereto (45 CFR Parts 160 and 164), any amendments or regulations relating to the privacy or security of health care information.
15) Maintain reasonably detailed records of services rendered to the Town. The Medical Director recognizes the Town has the right to inspect records and audit invoices both before and after payment, and that the payment by the Town does not affect the Town's right to recover excessive or improper charges.
16) Keep confidential information regarding disciplinary matters confidential unless disclosure is required by law.
17) Materials developed by the Medical Director under this Agreement will be the property of the Town. At the termination of the Agreement, the Town maintains the right to the utilization of any materials developed under this Agreement for its own internal operational and educational purposes including written, audio, video and electronic formats without respect to copyright to the Medical Director of the materials.
18) The Medical Director may suggest and specify actions be taken by the Town to correct deficiencies noted in the total quality management process or to correct violations of federal, state, and local law or regulations.

Town agrees to the following:

1) To provide the Medical Director with administrative support, as necessary.
2) The Town of Rockport agrees to pay a stipend of $3,000 annually for the responsibilities of the Medical Director.
3) The total of $3,000 will be paid out in two bi-annual stipends of $1,500 each, one on or around July 1st of the fiscal year and one on or around January 1st.
4) The Town of Rockport agrees to extend all applicable legal administrative coverage through the town's insurer, Maine Municipal Property and Casualty Risk Pool, for the person appointed as the Medical Director for the duration of their tenure.

Miscellaneous:
Notices. Any notices or other communications by either Party to the other shall be in writing. If mailed, postage shall be prepaid, registered, or certified mail and addressed as follows:

To the Town :
Jonathan R. Duke, Rockport Town Manager
101 Main St.
Rockport, ME 04856

To Medical Director:
Stephen Skinner, MD
Department of Emergency Medicine
PenBay Medical Center
6 Glen Cove Drive
Rockport, ME 04856

Or to any such other address and to the attention of any such other person or officer as either Party may appoint by notice.

No Waiver: Neither the failure by the Parties to insist upon strict performance of any provision of this agreement, nor to exercise a remedy consequent upon a breach thereof, nor the acceptance of full or partial performance during the continuance of any breach by the other, shall constitute a waiver of any such breach.

Further Instruments or Action: Each party agrees that it will execute and deliver such further instruments and will take such further action as may be reasonably necessary in order to effectively discharge of performance or conduct any of the respective obligations and agreements hereunder.

Surviving Obligations: Notwithstanding the termination of this Agreement, the Parties shall be required to conduct any provisions hereof which contemplate performance of or completion by a party subsequent to such termination, and such termination shall not affect any liability or obligation which shall have occurred prior to any such termination.

No Requirement to Refer: It is not the purpose of this Agreement to induce the referral of patients. The Parties acknowledge that there is no requirement under this Agreement or any other agreement between them that either Party refer patients to the other for products or services. All considerations hereunder are at fair market value. No payment under this Agreement is in return for the referral of patients, if any, or in return for the purchasing, leasing

or ordering of any products that will be paid for by any federal healthcare program. The Parties may refer patients to any person or other entity providing such products as consistent with professional medical judgment and the needs and wishes of the individual patients.

Governing Law: This Agreement shall be construed, and all the rights, powers, and liabilities of the parties hereunder shall be decided in accordance with the laws and in the courts of the state of Maine.

Agreement in its Entirety: This Agreement sets forth the entirety of the understandings between the Parties. No prior or subsequent understandings of the Parties or their agents shall be enforceable under this Agreement unless the Parties agree in writing to an Addendum to this Agreement.

SIGNED:

Authorized Town Representative	Town Manager Title	12/20/24 Date
Medical Director	M.D. Title	12/20/2024 Date

Schedule A: Deliverables

Activity	Quarterly	Annual
Quarterly Meetings with training staff	1hr.	4hrs.
Educational sessions	1hr.	4hrs.
Other meetings as necessary to represent Town's interest	1hr.	4hrs.
Total	3hrs.	12hrs.

Town of Rockport, Maine

Town Manager's Office
Town Office
101 Main Street
Rockport, Maine 04856

Jonathan Duke, Town Manager
Telephone: 207-236-0806 x3
Fax: 207-230-0112
Email: jduke@rockportmaine.gov

Date: October 7, 2024

To: Maine Board of Emergency Medical Services

Re: Letter of Intent for Transporting License

Dear Maine EMS Board Members,

I am writing this letter to satisfy the requirements of the Maine EMS Rules, Chapter 3, Subsection 5.1.E.2.

As I am sure you are aware, through granting previous licensing and permit requests that the Town of Rockport has chosen to take steps to move away from a contracted agreement with North East Mobile Health and create a municipal fire-based service operated and governed by the town.

Today, Fire Chief Jason Peasley and I met with Rick Petrie, CEO of NEMHS, and Jon Powers, NEMHS Division Chief, to discuss how the Town of Rockport's new EMS service and NEMHS can collaborate to ensure a seamless transition for our residents. The current contract between Rockport and NEMHS ends June 30, 2025 and contains an early termination clause. NEMHS has been made aware verbally and in writing the Town of Rockport will act upon cancellation of the contract prior to the completion of the contract.

While NEMHS has made it clear they wish to cooperate with the Town of Rockport once our service is operational NEMHS does not intend to relinquish their role as the primary provider nor support our application for licensure as a transporting authority. As the chief executive for the Town of Rockport, I do not feel this is in the best interest of my community. The citizens of the town have expressed, through the voting process that they no longer wish to leave our public safety decisions in the hands of a disconnected third-party vendor that has not met the expectations of the town. Further, our community conducted a public process to discuss and examine the options before Rockport prior to our voters' overwhelming choice to support a municipally based EMS service at the polls in June. The will of our voters in considering this matter must weigh heavily in this process.

Therefore, I am submitting this letter not only to meet the requirements of item 5.1.E.2.a, but also to challenge any necessity of the town to meet requirement item 5.1.E.2.b. The EMS

coverage for the Town of Rockport, provided by NEMHS, is completed under the auspices of a legal contract. Once this contract is legally and rightfully terminated, NEMHS has no cause or claim to the primary response responsibilities within the borders of the town as it is against the wish of the voters and the town administration as we will be capable of providing those services on our own. A private business cannot hold its taxpayers for ransom, essentially attempting to punish them for choosing to have the town provide its own public safety.

Rockport will be fully operational as a 24hr capable EMS service by November 30, 2024. The town respectfully requests that you approve our transporting license effective that day at 0700hrs and if need be, terminate NEMHS's primary license for the Town of Rockport so the there is no confusion or misrepresentation of responsibilities for the citizens of Rockport.

We ask that this matter be addressed promptly with approval of our transport licensure application. I am more than happy to address any questions regarding this issue.

Respectfully,

Jonathan Duke
Town Manager

ROCKPORT FIRE DEPARTMENT

POB 142, 85 Main St. Rockport, ME 04856 (207) 236-4437

October 9th, 2024

To: Maine Board of Emergency Medical Services

From: Jason Peasley, Rockport Fire Chief

Re: Transporting License Needs Assessment and Waiver Request

Members of the Maine EMS Board,

Please accept this letter accompanying our application for a transporting service license for the Town of Rockport Fire Department. The following information meets the requirements set forth in Chapter 3, Subsection 5.D and 5.E. This primary license will be for the Town of Rockport only.

Our requested Primary Response Area will be the Town of Rockport. The licensure is to be at the EMT Level, permitted to the Paramedic Level. The town has a current population of 3,644 (per 2020 Census) spread out over 33.34 square miles. Our expected enroute time will be less than three minutes with a tolerance of +/- five minutes. Our anticipated response time is no more than 8 minutes to any boundary within our primary response area. Our expected transport time is no more than 10 minutes, with all patients going to the closest hospital, Pen Bay Medical Center. A tolerance of +/- 5 minutes of that transport time is expected depending on location of call, traffic and seasonal weather.

The Rockport Fire Department intends to commence staffed 24hr operations on 12/1/2024. This crew will be committed to emergency responses only; no IFT or local transfer services will be provided. Our anticipated transporting call volume will be 600 calls per year, based on information provided from the current primary emergency provider. We service no assisted living communities or nursing homes in the requested primary response area. We have three major roadways within our requested primary response area, all of which provide direct and alternate routes to our primary receiving hospital.

- NEMHS arbitrarily chose to increase the contract required response time from 9 minutes to 11 minutes in the 20-21 contact amendment with no reason provided.
- Every major increase (254% in 2018 and 132% in 2024) has been provided with minimal notice prior to budget season.

- The town has invested in the infrastructure and staffing, as denoted by our current and forthcoming EMS license application, to provide a dedicated service to the residents of Rockport at a higher level than what is contractually provided at this time.
- We understand that a third party consultancy report would likely recommend regionalization and we do agree with that concept. Several communities in this area, including ours, have completed such studies in recent years that have also supported this idea. In the future we would entertain such discussions. Waiting for a study that tells us what we already know would be futile, wasting taxpayer time and money. Avoiding this was a goal of our suggested transition with NEMHS, which was refused.

Given all the above noted information, as well as our demonstrated commitment and preparation to provide the best service possible for our residents, we respectfully request the granting of the primary transport licensure status of our service for the response area of the Town of Rockport.

We are confident that we have done everything we can to make this an effective, amicable transition. At this point, our primary focus must be on providing the best service to the residents of and visitors to the Town of Rockport.

We appreciate your review of the material offered and look forward to a timely response and approval.

Respectfully,

Jason Peasely, Fire Chief

https://www.midcoastvillager.com/news/rockport-begins-24-hour-paramedic-service-in-december/article_0b3b21ec-a1f5-11ef-ba45-4765d7f7d12c.html

PUBLIC SAFETY

Rockport Begins 24-Hour Paramedic Service in December

Rockport Fire has hired paramedics and plans to start fulltime coverage Dec. 15.

By Daniel Dunkle
Nov 21, 2024

Pictured, from left, are Rockport's new paramedics, Jen Harden, Jen Oliveira, Tim Oliveira and Corey Bonnevie. Photo courtesy of Rockport Fire

ROCKPORT — Fire Chief Jason Peasley is upbeat as the town hires paramedics and prepares to launch its 24-hour EMS service under his leadership.

"There is a significant benefit to all of the communities in this area by Rockport Fire adding the EMS," he said. "We are bringing on eight additional EMS personnel to help cover the town of Rockport... We are guaranteeing a dedicated 911 ambulance as well as guaranteeing a paramedic on every truck. Overall, this is increasing patient care and the service for the Midcoast. There is no downside to Rockport having EMS to these communities."

The new paramedics will start their shifts Sunday, Dec. 15.

The new hires include Jen Harden of Liberty, who brings four years of experience in Emergency Medical Care, coming from United Ambulance, running over 20,000 calls a year. She has also served on Liberty and Stockton Ambulance. She lives in Liberty with her husband and two sons.

Also new to the team is Jen Oliveira, an 18-year paramedic for Fall River, Massachusetts, running over 26,600 calls a year, most recently serving as captain of operations. She and her husband Tim have family in the Midcoast and recently purchased a home in Union, where they are moving this month.

Tim Oliveira has also joined the team. He is a 16-year paramedic, also for Fall River, working his way up the ranks, and most recently serving as chief of EMS.

Corey Bonnevie was also hired. He is a 24-year paramedic starting in Raleigh, North Carolina, in metropolitan and tactical settings, moving to Maine to work as a wilderness medic in Rangely for several years before taking over as deputy EMS chief in Liberty.

The new EMS team includes four full-time firefighter EMTs and four fulltime paramedics, according to Peasley, and will operate 24-hour shifts, 365 days a year.

"Over the last year we have hired four fulltime firefighter EMTs," Peasley said. "Mike Root, who is an assistant chief in Owls Head and firefighter with Thomaston; Jamie Leo, deputy chief for Thomaston; Robert 'RJ' Polky coming from Federal Wildland Firefighting; and Ryan Nizolek from Vinalhaven, EMS chief and formerly a U.S. military combat medic.

“We are very fortunate to be starting our EMS program with four highly qualified firefighter EMTs with over 60 years of experience in both fire and EMS as well as four paramedics with over 55 years of EMS experience,″ he said. “This group will be able to hit the ground running with excellent patient care, quality of service and faster response times.”

The team has already had joint trainings will Rockland Fire and EMS to start building that mutual aid relationship, and work as a team, he added.

“We have 10 additional per diem firefighter EMTs and medics to assist with covering shifts as needed that are now on our roster,” Peasley said.

Peasley is overseeing all Fire and EMS and Corey Bonnevie will be the EMS supervisor.

As for ambulances, the town has one “loaner” now, and its new ambulance is due to arrive at the end of January or beginning of February. Greenwood Emergency Vehicles has offered to sell the loaner to the town as a backup.

Peasley said the plan is to have one ambulance in each station — Rockport and West Rockport — with sleeping quarters and main offices in the new station at West Rockport. Staff will be in both stations daily for truck and equipment checks.

Asked if this will be a full integration of the fire department and EMS like Rockland, Peasley said, “Rockport will be run very similar to Rockland, just on a smaller scale. Rockland is our primary mutual aid partner when additional ambulances and staff are needed.

“We are starting with this full-time model until call volume or need dictates a change,” he said. “We are starting talks with hopes of working closely with Rockland Fire and EMS with possible regionalization and shared paramedics and equipment services. Rockland is currently the closest EMS department to our town.”

The town has also been working on completing all of the required paperwork with state agencies to secure needed permits and certificates. It is currently waiting on the final transport license from the Maine EMS Board, which it is meeting with in early December. Until that license is secured, the town will continue sending first responders to help people at the scene, and transport to the hospital will be through North East Mobile Health Services.

Town Manager Jon Duke said in a recent Select Board meeting that North East could relinquish the transport and billing to the new Rockport department, but so far has not done that. The town has given North East the required 180-day notice of termination of services with the town, and the town will secure its own license to be able to take over transport and billing.

However, Peasley adds, ″We hope that we will be able to work closely with all EMS services in this area, as well as support NEMHS in any way we can. By Rockport assuming EMS responsibilities for our town, this allows NEMSH to focus more of their time and personnel to the other three communities they service.″

In terms of funding, Peasley said, “It’s taken three years of planning, research and development to get a budget put together with staffing levels and equipment to ensure the citizens are going to get the proper EMS care they deserve. Budgeting is never easy, especially in this type of service. With our Finance Director Megan Bracket, we are in line of what the voters passed for the 2024/2025 budget. ...We do not foresee any significant changes.

“This is a very exciting time for all of Rockport, its citizens and our department to be able to significantly increase our emergency services for our community,″ he said. ″We cannot thank all our citizens enough for the overwhelming support they have shown throughout this entire process as well as the confidence they have in our team.”

Daniel Dunkle
Executive News Editor

Knox County Commission
Knox County Courthouse
62 Union Street
Rockland, Maine 04841

November 11, 2024

Maine Emergency Medical Services
45 Commerce Drive
Augusta, Maine 04333

Re: Fire Department, Town of Rockport Maine

Dear Board of Emergency Medical Services,

As the Commissioner for Knox County District 3 representing Rockport, I am writing to support the Rockport Fire Department's efforts to start a municipal ambulance service to replace the private contractor currently in use, and provide emergency medical services to people of the community.

As the community grows and services are more in demand, this service is supported by residents who have allocated funds to start the service, hire new workers, purchase a new ambulance, and build a new fire station that will accommodate the department's expanded service.

There are many benefits to having local control over emergency services. Patient care is better and more consistent, response times are faster, and community members providing the care have a vested interest in those they serve.

With an emergency medical service that is "in house," Rockport will have control over the personnel they hire, as well as their training, education, professionalism, and equipment. System efficiencies and use of resources will be improved as well.

I fully support Rockport's efforts to provide municipal ambulance service to its community.

Please feel free to contact me for further information or comments.

Thank you,

Sharyn Pohlman, Knox County Commissioner, District #3

Representing: Rockport, Camden, Hope, Owls Head, North Haven, Vinalhaven, Matinicus, Isle au Haut, and the unorganized territories of Criehaven Island and the Muscle Ridge Islands.

North East
Mobile Health Services

Saco - Rockport - Jackman

November 13, 2024

Maine EMS Board
152 State House Station
Augusta, Maine 04333-0152

Members of the Board-

I am writing to express our objection to the transporting service application filed by Rockport Fire Department.

North East Mobile Health Services (NEMHS) is the current 911 EMS provider for the towns of Camden, Rockport, Lincolnville and Hope. We have held the 911 contract for these towns for more than 10 years and have spent a significant amount of time and money establishing a quality emergency response program for the residents and visitors of these towns. Our contract with the towns includes both oversight and response requirements, and we have consistently met or exceeded those requirements during the time that we have been contracted to provide 911 service. We have been able to deliver an efficient and fiscally responsible program by having a regional delivery system and providing non-emergency transport to bring in additional revenue.

The current contract requires the following standards to be met by NEMHS:

Response Level

NEMHS shall or shall cause an immediate response for emergency medical services with a paramedic staffed vehicle for 95% of ALS calls as defined above. *(Advanced Life Support is defined in the contract as calls dispatched with the "ECHO" (E), "DELTA" (D), and "CHARLIE" (C), determinant codes)*. Response Level will be measured by combining the response level for all four towns.

As per Section VIII NEMHS shall have mutual aid agreements in place in the event NEMHS cannot immediately respond to any call for emergency service.

Average Response Time Performance Requirements

"Response Time" is defined as the total time from when the call ls dispatched by Knox County Regional Communication Center to NEMHS to the time NEMHS's ambulance arrives at the Incident. Average Response time for the TOWNs are listed below.

	Contract Avg
Town	**Resp. Time**
Camden	0:09:00
Hope	0:18:00
Lincolnville	0:19:00
Rockport	0:09:00

I have attached reports showing our compliance with the standards set in the contract, and we have never paid a fine for missing our response level or time parameters. Additionally, as you will see from the reports, we have been able to significantly reduce our requests for mutual aid coverage, while *providing* mutual aid response/intercept to other towns during that same time frame as follows:

Incident Year	2020	2021	2022	2023	2024
Intercept	31	35	20	25	25
Mutual Aid	22	43	37	36	34
Standby	28	12	10	28	32

If Rockport is granted their request to start a transport service with one ambulance, we are concerned that it will put additional strain on the mutual aid system in the area.

The Legislature felt strongly that Maine needed an evaluation process for starting a new transporting service because they heard about the tremendous difficulties encountered by communities and EMS agencies when new transporting services were established in areas already being served by existing ambulance services. In 2021, they passed a law (Title 32, Chapter 2-B, §86 (1)(A)) requiring the Maine EMS Board to adopt rules for this process, and the Maine EMS Board unanimously adopted those rules in the spring of 2024 (Chapter 3, §5, 1(E)).

Approval of Rockport's application to become a transporting service will break up an established regional EMS delivery system leading to inefficiencies, both operationally and financially, and is in direct contrast to the needs of both the residents/visitors in the Mid-Coast area and the EMS system in Maine. If allowed, the three remaining towns will have to absorb not only the subsidy currently paid by Rockport, but also the lost revenue, resulting in a per capita cost increase of more than 78%.

There have been three public safety studies conducted in this area, two by Neil Courtney and one by Kevin McGinnis, and all three advocate for a regionalized approach. Maine EMS has copies of all three reports for your review.

Thank you for consideration of our concerns, and I am available to answer any questions you may have.

Sincerely,

Rick Petrie, EMT-P
Chief Executive Officer

North East
Mobile Health Services

Summary of Responses
Municipal Contract Requirements
2020 – 2024*

Average Response Times

		2020			2021			2022			2023			2024*		
City	Contract Time	Total Responses	Chute Time	Response Time	Total Responses	Chute Time	Response Time	Total Responses	Chute Time	Response Time	Total Responses	Chute Time	Response Time	Total Responses	Chute Time	Response Time
Camden	0:12:00	783	0:01:36	0:07:43	909	0:01:34	0:09:43	871	0:01:38	0:09:32	1,108	0:01:47	0:09:42	809	0:01:38	0:09:07
Hope	0:20:00	83	0:01:30	0:14:12	91	0:01:32	0:16:37	97	0:01:29	0:15:02	99	0:01:37	0:15:36	92	0:01:44	0:15:44
Lincolnville	0:22:00	130	0:01:43	0:10:42	205	0:02:05	0:18:07	252	0:01:40	0:17:48	240	0:02:01	0:18:35	150	0:01:36	0:17:16
Rockport	0:11:00	324	0:01:42	0:06:18	497	0:01:37	0:08:04	468	0:01:25	0:08:05	557	0:01:38	0:07:53	459	0:01:27	0:07:00
Total		**1,320**	**0:01:38**	**0:08:05**	**1,702**	**0:01:38**	**0:10:34**	**1,688**	**0:01:34**	**0:10:39**	**2,004**	**0:01:41**	**0:10:32**	**1,510**	**0:01:35**	**0:09:37**

Chute Time – Time Unit Notified to Time Unit Enroute
Response Time – Time Unit Notified to Time Unit Onscene

Total C/D/E calls with a Paramedic

	2020			2021			2022			2023			2024*		
City	Total Responses	With Medic	%	Total Responses	With Medic	%	Total Responses	With Medic	%	Total Responses	With Medic	%	Total Responses	With Medic	%
Camden	284	281	98.9%	194	193	99.5%	289	286	98.9%	370	360	97.3%	350	341	97.4%
Hope	38	38	100%	30	30	100%	42	42	100%	34	33	97.1%	47	45	95.7%
Lincolnville	76	76	100%	41	41	100%	69	69	100%	81	80	98.8%	67	67	100%
Rockport	147	146	99.3%	75	75	100%	170	170	100%	172	171	99.4%	186	181	97.35
Total	**545**	**541**	**99.3%**	**340**	**339**	**99.7%**	**570**	**567**	**99.5%**	**657**	**644**	**98.0%**	**650**	**634**	**97.5%**

Mutual Aid Requests

City	2020	2021	2022	2023	2024*
Camden	19	9	15	17	8
Hope	0	1	0	1	0
Lincolnville	3	4	7	3	1
Rockport	9	5	8	10	1
Total	**31**	**19**	**30**	**34**	**10**

Transports

	2020			2021			2022			2023			2024*		
City	Total	Transports	%	Total	Transports	%	Total	Transports	%	Total	Transports	%	Total	Transports	%
Camden	783	537	68.6%	909	605	66.6%	871	660	75.8%	1,108	751	67.8%	809	538	66.5%
Hope	83	51	61.5%	91	51	56.0%	97	70	72.2%	99	54	54.5%	92	59	64.1%
Lincolnville	130	90	69.2	205	126	61.5%	252	141	56.0%	240	122	50.8%	150	68	45.3%
Rockport	324	205	63.3%	497	293	59.0%	468	292	62.4%	557	291	52.2%	459	260	56.6%
Total	**1,320**	**883**	**66.9%**	**1,702**	**1,075**	**63.2%**	**1,688**	**1,163**	**68.9%**	**2,004**	**1,2,18**	**60.8%**	**1,510**	**925**	**61.3%**

*2024 – January 1 to September 30

HOUSE OF REPRESENTATIVES
2 STATE HOUSE STATION
AUGUSTA, MAINE 04333-0002
(207) 287-1400
TTY: MAINE RELAY 711

Vicki Doudera
18 Trim Street
Camden, ME 04843
Residence: (207) 542-1990
Victoria.Doudera@legislature.maine.gov

November 6, 2024

Maine Emergency Medical Services
45 Commerce Drive
Augusta, Maine 04333

Re: Fire Department, Town of Rockport, Maine

Dear Board of Emergency Medical Services,

As the legislator from the Maine House of Representatives for the town of Rockport, Maine, I write in strong support of the Rockport Fire Department's efforts to start a municipal ambulance service to replace the private contractor currently in use and provide emergency medical services to people of the community.

I believe that this change is in the best interest of Rockport residents who have overwhelmingly indicated their support by allocating funds to start the service, hire new workers, purchase a new ambulance, and build a new fire station (nearly complete as I write this) that will accommodate the department's expanded service.

As a former emergency medical responder myself, I know firsthand the benefits of having local control over emergency services. Patient care is better and more consistent; response times are faster: and community members providing the care have a vested interest in those they serve. With an emergency medical service that is "in house," Rockport will have control over the personnel they hire, as well as their training, education, professionalism, and equipment. System efficiencies and use of resources will be improved as well.

My days driving an ambulance are behind me – for now at least – but I well remember the comfort and care I was able to bring my neighbors and friends as a well trained emergency medical provider. I commend Rockport for wanting to offer this same level of care and urge you to help them establish their municipal ambulance service so it can be up and running as soon as possible.

Please do not hesitate to contact me for further information or comments. Thank you very much.

Sincerely,

Victoria W Doudera

Vicki Doudera, State Representative

131st Legislature
Senate of Maine
Senate District 12

Senator Pinny Beebe-Center
3 State House Station
Augusta, ME 04333-0003
Office (207) 287-1515

November 13, 2024
Maine Emergency Medical Services
45 Commerce Drive
Augusta, Maine 04333

Re: Fire Department, Town of Rockport, Maine

Dear Board of Emergency Medical Services,

As the State Senator representing the town of Rockport, Maine, I write in strong support of the Rockport Fire Department's efforts to start a municipal ambulance service to replace the private contractor currently in use and provide emergency medical services to people of the community.

I believe that this change is in the best interest of Rockport residents who have overwhelmingly indicated their support by allocating funds to start the service, hire new workers, purchase a new ambulance, and build a new fire station that will accommodate the department's expanded service.

A locally owned EMS department would give residents more consistent, quality care, as well as letting patients know that they are being looked out for by people who truly know them and care for them. I want the people of Rockport to have that peace of mind that when they call for help, an experienced member from the community will be there. I applaud Rockport for wanting to make this change, and I urge you to help them establish their municipal ambulance service.

If you have any questions for me, please feel free to reach out.

Sincerely,

Pinny Beebe-Center
State Senator
District 12

Timothy Andersen

709 West Street
Rockport, Maine
04856

11/7/24

Hello, this is Tim Andersen, and I am a resident of Rockport. I'd like to relay details of an incident which occurred with Northeast EMT in early November of 2022.

As background, while visiting for the weekend, my daughter passed out in the shower, hit her head and was unconscious in our guest bath. Her husband ran in after we heard her fall, and upon seeing her, we immediately dialed 9-1-1. That was at 11:13 a.m., I believe, and it wasn't until after 11:45 that North East arrived, so we're looking at a response time of over 30 minutes. We're not in a remote location - quite the contrary, we're very visible, and right on Rte. 90. Upon arrival, my wife met the 2 EMTs in the driveway, and they didn't seem overly concerned or in a hurry to get inside and see my daughter.

In addition, we later learned that Rockland offered to respond and was told not to, as was Waldoboro, who actually drove by our house while my wife was waiting outside! Also, we were told that Northeast incorrectly "prioritized" the severity of the call.

Overall, I thought that the response time was poor, and accordingly, I support Rockport Fire taking over EMT services from the current private contractor.

Sincerely,

Tim Andersen

Timothy Andersen

709 West Street
Rockport, Maine
04856

11/7/24

Hello, this is Tim Andersen, and I am a resident of Rockport. I'd like to relay the details of an incident which occurred with Northeast EMT in May of 2023.

My mother-in-law, Grace Stearns, a Camden resident, suffered a bad fall at her home on Mechanic Street. My wife was working at Grace's rental property which is next door to her home, and when she got the call, she raced over to the property and called 9-1-1. While I don't know the exact response time, Camden Fire arrived well before Northeast EMT, who claimed that they got lost on the way (Mechanic Street is a well-known street in Camden), and Northeast only sent on person to respond. There was no way this one person could have gotten Grace into the ambulance without the help of the Camden FD.

Overall, I thought that both the response time and personnel sent were inadequate, and accordingly, I support Rockport Fire taking over EMT services from the current private contractor.

Sincerely,

Tim Andersen

Office of:

Town Manager
Tax Assessor
Tax Collector
Town Clerk
Treasurer
Code Officer
Finance Director
Harbor Clerk

"Where Mountains Meet the Sea"

Town Office

P.O. Box 1207
29 Elm Street
Camden, Maine 04843
Phone (207)236-3353
Fax (207)236-7956
http://www.camdenmaine.gov

November 15th, 2024

Maine EMS Board
152 State House Station
Augusta, Maine 04333-0152

RE: Town of Rockport – Application for Transporting Ambulance Service

Dear Members of the Board:

As all of you are aware, the Town of Rockport currently participates in a multi-town collaboration with Camden and neighboring communities to contract with Northeast Mobile Health Services to provide a transporting ambulance service. While we respect Rockport's desire for autonomy and local control, we feel it is important to outline the potential impacts of this decision on the Town of Camden and other communities in our region.

Our communities currently provide a subsidy to fund our contract with NEMHS, which is apportioned to the four participating communities based on population. Therefore, the financial impact of Rockport's exit from this regional service will have a significant financial impact on the Town of Camden, the largest community per capita amongst the four towns. Currently Camden's subsidy to NEMHS accounts for 41% of the total cost, which will increase to 57%. In dollars this is an annual increase from $363,677.49 in FY25 to $648,598.17 in FY26.

As in any small town, an increase of this magnitude will be exceedingly contentious to the point where it may be the most fiscally responsible decision for the Town of Camden to pursue starting our own transporting ambulance service. This would be incredibly negatively consequential for the provision of EMS in our region and to our neighboring towns. Therefore, starting our own transporting ambulance service is not the Town of Camden's preferred outcome and is counter to Camden's desire to more intensely strengthen EMS and Fire service collaboration within our region. Camden is steadily working to implement the recommendations of the attached Community Self Determination EMS Evaluation that Camden, Hope, Lincolnville, Rockport and Pen Bay Hospital – Maine Health participated in developing in 2020-2021. We are dedicated to continuing to work collaboratively with all our neighboring communities and NEMHS to ensure our region maintains high level EMS coverage for its residents.

Sincerely,

Audra Caler
Camden Town Manager

ATTACHMENT: Modified Informed Community Self Determination EMS Evaluation Final Report

Modified Informed Community Self Determination (ICSD) EMS Evaluation in and for the Towns of Camden, Hope, Lincolnville, and Rockport and the Pen Bay Medical Center - Final Report

I. Executive Summary

The towns of Camden, Hope, Lincolnville and Rockport have received 9-1-1 emergency medical services (EMS) response coverage from North East Mobile Health Services (NEMHS – a private company based in Scarborough, Maine) since 2013. For some 77 years before, that service was provided by the Camden First Aid Association (CFAA), a non-profit ambulance agency overseen by a community board. Pen Bay Medical Center (PBMC) had been served by NEMHS prior to 2013 to transport its patients requiring certain emergency services to other facilities (called "inter-facility transport" or IFT) for that care. In mid-2020 and anticipating the NEMHS contract conclusion on June 30, 2021, PBMC and the towns of Camden and Rockport sought advice on weighing options for future EMS coverage. This report summarizes the process that ensued.

In the most recent years of NEMHS' service to the area, increasing discussion among local public safety, government and hospital officials about satisfaction with elements of that service has occurred. Presentations of potential fire-based EMS alternatives for 9-1-1 response have been entertained, and PBMC continues its use of NEMHS but without a current contract. A Maine-based EMS system professional was asked to lead this project utilizing aspects of the EMS "informed community self-determination" (ICSD) approach he had developed with other national experts. He and two colleagues served as Project staff to conduct an evaluation of the current service within an overall process to determine what options, in addition to a status quo option (in other words, no change from the current service) would best serve the area, and who would make the decision in choosing among options.

An initial Steering Group was selected by the towns of Camden and Rockport and PBMC to guide the Project and to review and approve its modified ICSD process in summer, 2020. In subsequent meetings, the Steering Group invited and added representatives selected by Hope and Lincolnville and helped to translate findings into recommendations for the Project. An initial example of this was a recommendation based on Project staff input to not proceed with a request for proposals (RFP) for EMS service in the area as an option. Staff research indicated that EMS workforce constraints in Maine EMS agencies, uncertainty created by the pandemic and other issues made that a likely unpromising route.

Through Fall and Winter as the evaluation component continued, the Steering Group met frequently (weekly at times), and reviewed staff research and findings, developing what evolved into ten potential options. In early 2021, it became evident to the Steering Group that issues identified in the evaluation precluded consideration of a status quo option because at least some contractual changes with NEMHS would be needed if it continued service. The Steering Group considered other options that called for starting a new fire-based service or a joint NEMHS/fire service venture. They felt that these had

possibilities but not in the timeframe beginning July 1, and especially in the uncertainty of the operational and financial environment created for EMS and PBMC by the pandemic.

Ultimately, the Steering Group consulted with the select boards as the decision-making entities at this level, to select an option to present to taxpayers in the referenda that COVID conditions dictated would be used in place of town meetings. The town decision-makers agreed with an option that called for continuing NEMHS for an additional one-year contract with an option for a second year. The contract would contain a number of new provisions that addressed issues identified in the evaluation and included operational and medical leadership staffing and communications, accountability and reporting, and participation in accreditation and other processes that better assure performance oversight and improvement. NEMHS and PBMC renewed communication about interfacility transport and other joint issues identified in the evaluation.

This option also recommended that a fire-based first response unit be formed in the four towns in an initiative with one town serving as the Maine EMS licensee and administrator, the same or another town providing the EMS chief, but all four towns benefitting and soliciting members. The four towns would contribute to a small fund to cover insurance, licensing and other administrative costs, but would individually budget to equip and pay for first responders answering calls in their towns.

Finally, the option recommended that the towns sponsor an EMS regionalization planning project in 2021-2022, guided by an experienced municipal planner, to evaluate the options for a new form of service to address EMS and possibly fire service needs. Other area towns would be invited to participate. An estimate of cost was received from a planner approved by the Steering Group.

The financial impact of this option for the towns would be:

- A .6% increase for the NEMHS contract for 2021-22 based on the New England Consumer Price Index,
- A population apportioned split of $20,000 for the regional planning initiative,
- A population apportioned split of $1,200 for the first responder unit administrative costs.

Table 1

Town	2010 Population	2010 Population %	2019-20 NEMHS Contract	2020-21 NEMHS Contract	2021-22 NEMHS Contract	2021-22 Regionalization Plan Initiative	2021-22 1st Responder Admin. Costs
Camden	4,851	41%	$122,066	$123,202	$123,941	$8,200	$492
Rockport	3,330	28%	$83,810	$84,138	$84,643	$5,600	$336
Lincolnville	2,164	18%	$54,463	$54,089	$54,413	$3,600	$216
Hope	1,536	13%	$38,658	$39,064	$39,298	$2,600	$156
Total	11,880	100%	$298,997	$300,492	$302,295	$20,000	$1,200

II. Background and Project Overview

Community-based emergency medical services (EMS) find themselves somewhere between the all-volunteer, first-aid providing, donation-supported rescue service which first came to be and the all-paid, paramedic, professional health care operation of a hospital, fire or other municipal department, or private company now common in most cities.

The public's expectation of the EMS professionals who arrive at their door is high. In 1973, the public expected no more than a lights and siren, "horizontal taxi" ride to the hospital frequently provided by community volunteers. By 1983, the media-influenced public didn't know whether to expect just the fast ride to the hospital or life-saving care in the back of the ambulance. But by 1993, a Maine EMS study showed that almost 90% of Maine's citizens expected paramedics (the highest level of EMS capabilities) to arrive at their doorstep for their heart attack. With media influence, there is no reason to believe they expect anything different today regardless of what is actually available.

Most emergency medical services are moving from the volunteer/basic care end of the spectrum to some point closer to the paramedic, all-paid end in urban and suburban centers. Rural EMS agencies face challenges in doing so, because of intertwined transport volume, financial and workforce availability issues exacerbated by the declining availability of other health care resources in their communities. The need to transport patients to more distant urban facilities to which higher levels of health care have gravitated takes ambulances away from availability for 9-1-1 response.

The Camden-Rockport-Hope-Lincolnville area was served for 77 years by the Camden First Aid Association until financial issues led to a significant increase of subsidy request to the four towns in 2013. Subsequently, the towns contracted with North East Mobile Health Services ("NEMHS") for 9-1-1 service. Additionally, NEMHS has already been and continued to be a principal transporting agency for patients transported out of Pen Bay Medical Center (PBMC) in Rockport.

NEMHS' initial contracts with the towns have been renewed to date with all four town agreements aligned for a common sunset date of July 1, 2021. There have, however, been increasing discussions among principals in the towns and the hospital about NEMHS's ability to meet the demands of 9-1-1 response and the interfacility transport needs of PBMC. These discussions resulted in a request, with approval of the town and hospital parties involved, to Kevin McGinnis to utilize a modification of an EMS evaluation process called Informed Community Self-Determination (ICSD) to study the situation and provide options for future action.

Finally, for the sake of transparency, the principal advisor in this process, Mr. McGinnis, is a past chief/CEO of NEMHS from 2011 to 2014 and advisor to NEMHS from 2014 to 2016. The hospital and Camden and Rockport town principals recognize this past affiliation and have requested this proposal regardless of that fact. In turn, Mr. McGinnis partnered with Michael Senecal, an experienced EMS director in western Maine, for the

evaluative components regarding NEMHS to assure objectivity. Enhancing this expert objectivity, the project also utilized Dr. Richard Narad, a California university health services systems faculty member and expert on EMS systems evaluation, comparison and contracting. The Project staff advisors and their backgrounds are in Appendix E.

III. Purpose and Format of the Evaluation

Kevin McGinnis and his associates, Mr. Senecal and Dr. Narad, (the Project Staff advisors), conducted an independent, objective evaluation of emergency medical services capabilities and needs in and for the towns of Camden and Rockport and for PBMC, and expanded to include Hope and Lincolnville. This evaluation produced a description of the current operation with recommendations for improved response and patient care as were indicated, and options for alternative delivery models. The advisors worked with the towns and PBMC through a Steering Group selected by them, and a local EMS expert and facilitator, to define the process by which these options will be considered and by which decision-makers. The advisors then assisted the towns and PBMC in informing the decision-makers about the process and options that they will consider. The scope of the contract spanned from evaluation to selection of an option, and was extended to include contract discussions with NEMHS. Subsequent implementation of the selected option was, otherwise, beyond that scope.

The advisors drew upon the ICSD evaluation process and template as they deemed relevant to this project. They worked with Tom Judge who was the local EMS expert/facilitator of the project staff and initial contact and project organizer with town and PBMC principals. The evaluation and recommendations components included, as the project evolved under the Steering Group's direction and as represented in this final report:

North East Mobile Health Services in the Camden-Rockport Area
This is an historical and quantitative picture of the services now provided. It provides decision-makers with a foundation of critical information from call and interfacility transport response profiles (call volumes, types, times, level of care and other response characteristics as available) to current staffing methods.

North East's Other Capabilities and Performance
This is a qualitative look at the functional effectiveness of the service. It is organized to assess critical components of an ambulance service such as governance, general operations, patient care, facilities and equipment, staffing, training, safety, budgeting/finance (as information is made available), and community relations/services. It will gather and analyze issues identified by stakeholders and/or observed by the advisors as a part of the foundation upon which to develop operational options for decision-makers to consider.

Camden-Rockport-PBMC: Options to Meet Community Needs for an Agile, Responsive EMS Resource

This section takes the NEMHS organization in the Camden area and Maine in general, as profiled in the previous two sections, and analyzes its strengths and weaknesses, as well as its opportunities and challenges. It then offers recommendations to make NEMHS, with consideration of possible fire department first response partners, a reasonable model for continuing its service to the area. Finally, other operational options and their relative cost implications will be considered by the Steering Group in an agreed-upon ICSD format.

IV. ICSD and the Camden-Rockport-PBMC Project

Rural and Frontier EMS Agenda for the Future, a book published by the National Rural Health Association in 2004, proposed the Informed Community Self-Determination (ICSD) model of community-engaged planning. It was designed to help communities with jeopardized EMS agencies redesign EMS services that fit with local tax-base and other resources and capacities and that reflect community preferences. Most simply stated, ICSD is designed to credibly inform taxpayers and/or their elected representatives regarding the type and level of EMS they currently have, reveal flaws or limitations to address, explain alternative levels of basic or advanced care and types of response that could be available, approximate the cost of adopting those alternatives, and facilitate a taxpayer decision to fund their current coverage or adopt a new plan. Specifically, ICSD provides a process in which:

- An outside expert or entity conducts an objective evaluation of the EMS service;
- The evaluator reports openly on the level of care, method/speed/availability of response and any issues which affect those factors;
- The evaluator reports any deficiencies which jeopardize service performance in order that they can be addressed immediately or entered into the ICSD discussion as indicated;
- Based on accepted national practices and state EMS law and regulations, options are presented and their implementation and financial impacts explained in terms of costs, projected revenues, other sources of funding, and the effects of changes on local, tax-based subsidies; and
- The community holds a meeting(s) of taxpayers and/or their representative decision-makers to select a level and type of service it desires and establish the level of funding needed to implement and sustain it.

In short, the ICSD process is designed for isolated rural communities with EMS operations in jeopardy and involves informing taxpayers or their authorized representatives about the type and performance of their EMS agency, what options for change they might consider, and at what cost to them. Then they are guided through a process to decide among the options.

The greater Camden EMS service area is not strictly the type intended for application of ICSD. It is more urban, wealthier, and includes multiple towns, a health-system affiliated

hospital with interfacility transport needs and, therefore, multiple sets of decision-makers. However, ICSD principles have been successfully applied in similarly more complex settings as well, addressing other EMS-related issues in Maine.

In this case, an evaluation of NEMHS' type and level of performance in meeting 9-1-1 and interfacility obligations was requested. Based on this evaluation, the current and alternative operational models addressing both 9-1-1 and interfacility needs would be described as options.

In the proposal for this process, it was specified that the project staff would "Meet with town, PBMC and North East principals to agree on the process to be followed in the project and execute the "Emergency Medical Services (EMS) Informed Community Self-Determination Program Agreement" (Appendix B of the ICSD template: https://nasemso.org/wp-content/uploads/2020-Template-for-Informed-Community-Self-Determination-v-6.1.pdf)". This would include a definition of the decision-making process and decision-makers to be involved. Because of the Project contracts established with Camden, Rockport, PBMC, and the Project staff, and the voluntary participation of NEMHS and two of the towns, the consensus on process developed throughout the Project by the Steering Group, sufficed to meet this ICSD agreement procedure. This was but one of the ways Project staff adapted the ICSD process to facilitate the needs of the stakeholders as allowed by the contracts in force.

The ICSD process initially utilizes a core group of key stakeholders to guide and help the staff through the evaluation and option development processes. In this Project, it included representatives of the Project clients, the towns of Camden and Rockport, and PBMC. As previously mentioned, it also included a volunteer facilitator who is a local resident and respected national EMS system expert and was a part of the original discussions among local town government, public safety and PBMC members about EMS coverage. He had been asked to help formalize this process by stakeholders and secured the consulting staff for the Project. After initial organizing meetings in the summer of 2020, the core group invited the Town of Hope and the Town of Lincolnville to be represented on the Steering Group as key stakeholders which included:

- **EMS Project Steering Group**
  - Tom Judge. Volunteer facilitator. Executive Director, LifeFlight of Maine.
  - Audra Caler-Bell. Camden Town Manager.
  - William Post. Rockport Town Manager.
  - Chris Michalakes, MD. Emergency Physician. PBMC.
  - Nancy Jackson, RN. Director of Emergency Services. PBMC.
  - Stephen Skinner, MD. Emergency Physician. PBMC
  - Sarah Ann Smith. Chair, Hope Select Board.
  - Thom Ingraham. Member, Hope Select Board.
  - David Kinney, Lincolnville Town Administrator.

The Project proposal and contracts were developed and completed through July and August, 2020 by the Project staff leader, the Towns of Camden and Rockport, and PBMC. The Project staff was assembled and began work in September.

The core of the evaluation included a review of Maine EMS, NEMHS, KRCC (Knox Regional Communications Center) and other data relevant to the functioning of EMS in the project area. This was accomplished by the three Project Staff advisors. An evaluation of NEMHS itself, including all relevant inspections of facilities, equipment, records, operating procedural and other materials, and interviews with leadership, staff, and KRCC officials was conducted by Mr. Senecal. Evaluation of contract materials and review of findings and recommendations as they emerged was done by Dr. Narad and Mr. Senecal, when presented or developed by Mr. McGinnis. The remaining interviews were conducted by Mr. McGinnis with some assistance by Mr. Senecal. Interviewees were those recommended by the Steering Group or on their own action by the Project staff (virtually all of these were accomplished with only a few who did not respond to multiple phone calls and/or emails; only two resulted from e-mail correspondence and not a direct interview). Interviewees were assured of anonymity in their participation and comments, but resulted in 43 interview sessions which included all or a sampling of the following (where "town(s) is cited it means the four Project towns unless otherwise specified):

- Town managers/administrators and other officials
- Town select board chairs and members, and past EMS Performance Review Committee members
- Town and neighboring fire department chiefs, other officials and a sampling of members
- Town and county law enforcement officials
- Knox Regional Communications Center staff
- Town residents and business operators
- PBMC leadership and staff
- Staff involved in emergency department operation in Waldo County General and Miles Memorial Hospitals
- Maine EMS and Atlantic Partners EMS (Mid-Coast EMS Council) officials
- NEMHS leadership and a sampling of Rockport-based EMTs/Paramedics

The first option to be considered was whether the towns and hospital could entertain a request for proposal (RFP) process, given a 2012-13 process for EMS in the area that was successfully concluded. The area has approximately 1,500 9-1-1 calls and 1,000 interfacility transports, making it a reasonable prospect for at least an in-state service to initiate an operation. Staff research revealed little interest from likely respondents to such an RFP given the EMS workforce fragility in Maine and regionally, and the operational and financial uncertainties created by the pandemic. The fluctuations in call volume and staffing needs among potential respondents and the uncertain future of the pandemic and its effects were specifically cited. The Steering Group was also concerned that an RFP might prematurely preclude, with long-term consequences, the opportunity for growth of a community-based service or a locally sponsored, regional service in the

future. The Steering Group agreed, then, not to attempt an RFP for EMS service in the area as an option.

The Project was originally planned to conclude in December, 2020. Since the process would not end with an RFP process, and the ICSD process is intended to match the timeframe for town and hospital decision-making which could extend through town meetings in June (or referenda if town meetings can't be held under pandemic precautions that may then exist), it was agreed during the fall Steering Group meetings that the Project would extend until its members' needs were met. This would be when an option, or options, was selected by the Steering Group and the towns and PBMC agreed that no further Project staff ICSD support would be required. There would be no additional cost for extending these services.

The Steering Group set a regular weekly meeting schedule through the fall and winter and met on most of those occasions for Project updates and to develop and select operational options to be considered. Ten options evolved from Project staff consideration of response data and issues revealed during the evaluation process and especially the interview component. Also, NEMHS and fire service leadership were solicited for ideas for further operational options and these were received and added to the mix. They were assured that details of their proposals would not be made public without permission. There was no need to do this as portions of their proposals were integrated into options anonymously as they evolved during Steering Group consideration.

As described below, one multi-part option emerged as clearly favored by the Steering Group while aspects of three others were recommended for further study as a part of the selected option. An in-person meeting was held for Project staff and a Steering Group member to explain the process, options, and potentially selected option to the four town fire chiefs. Project staff conferred with NEMHS leadership on the option that would likely be pursued. The PBMC Steering Group representatives conferred with leadership at the hospital throughout. Between the interview process and consultation with PBMC Steering Group members individually, the inter-facility transport priority of PBMC was addressed. There had been no specific contract in this regard since 2018, though staff of PBMC and NEMHS seemed to somewhat continue to abide by its provisions (e.g. method of requesting transports). During the ICSD process, a new Steering Team member was added by PBMC. This physician, Dr. Steve Skinner, is new to the area but is an EMS specialist who is becoming the EMS liaison for PBMC. The Project established a communication relationship between Dr. Skinner and NEMHS CEP Butch Russell with promise of discussions and a pathway to improving the leadership and operational communications issues identified by the Project. Dr. Skinner expressed that this, and other results of the Project, constituted a satisfactory result for the time being and that no further Project staff effort was required from his perspective.

Based on input from these informational meetings, details of the option were revised and budget figures further developed. Informational meetings were held on February 8 and 9 for the Lincolnville, Rockport, Hope, and Camden select boards on the Steering Group

process and option selected. A further meeting was held on March 25 for the Hope select board and budget committee.

Following these sessions, disagreements with budgeting for a first responder unit were raised. Some members felt that equipping and providing call pay for members responding in their towns would be less than the costs projected. As a result, these projected costs were taken off the proposed first response unit expense request to be apportioned to the towns. These would be managed internally by the towns in their budgeting processes. Only a $1,200 shared administrative cost would be requested to be apportioned to the towns.

Project staff researched alternative means for apportioning the EMS coverage and other shared costs of the option selected and over three weeks' meetings these were reviewed and discussed by the Steering Group, with time to review with their town colleagues. Finally, a population-based apportionment method using most recent census figures was chosen, as it had been in previous years.

V. North East Mobile Health Services in the Camden-Rockport Area

The towns of Canden, Hope, Lincolnville and Rockport have received 9-1-1 emergency medical services (EMS) response coverage from North East Mobile Health Services (NEMHS – a private company based in Scarborough, Maine) since 2013. For some 77 years before, that service was provided by the Camden First Aid Association (CFAA), a non-profit ambulance agency overseen by a community board. When financial and other difficulties evolved for CFAA around 2012, their ensuing request for an eight-fold increase in town subsidies led to a request for proposal process that attracted four candidates with NEMHS subsequently being awarded the contract.

Pen Bay Medical Center (PBMC) had been served by NEMHS prior to 2013 to transport its patients requiring certain emergency services to other facilities (called "inter-facility transport" or IFT) for that care. This relationship reflected NEMHS' pattern of serving the evolving Maine Health system service area, of which PBMC was increasingly a part, as widely as possible.

That CFAA was a community-based service gave it hometown characteristics that are appreciated in the area: local board and executive leadership, staff largely drawn from the communities served, and an informal "first response" capability created by ambulance staff listening to public safety dispatch radio traffic and assisting with calls in their home areas even when not on duty. CFAA was born out of the volunteer tradition common in EMS, and evolved into a version of a paid service also frequently the path of modernizing ambulance services in an era of declining volunteerism.

Volunteer services often depended on their appeal as a social organization to attract and retain members, while fully paid services implemented modern business and human resource development principles to succeed. CFAA's demise spoke of the pitfalls that

such services can also experience when the business acumen and leadership required of modern EMS agencies does not evolve as fast as the move from volunteer to paid service.

NEMHS is, by volume of calls, the largest of the Maine's ambulance service providers. It is based in Scarborough, has over 200 employees, and operates bases there and elsewhere in southern Maine. Its base in Rockport serves the Camden-Rockport area, and a base in Brunswick is a resource for additional ambulances and crews when Rockport's are busy. The NEMHS company is a private for-profit that shared roots in a family-owned venture that also created what is now Northern Light Medical Transport in Bangor.

Health care services such as NEMHS, that are "for-profit" entities, tend to be negatively cast to some degree, especially by others with whom they compete. In EMS, the fire service, which vies for the EMS role in the face of declining fire suppression needs, is a significant source of this tension for private services, including nonprofits. No EMS operator or sponsorship model has proven superior to another. This is fortunate, as Maine has a varied group of these among its 276 EMS first responder or ambulance agencies:

- 173 Fire Service First Responder or Ambulance Services (e.g. Rockland)
- 41 Non-Profit Community EMS Services (e.g. St. George)
- 35 Independent Municipal EMS Services
- 11 Private EMS Services (e.g. NEMHS, St. George)
- 11 Hospital-Based EMS Services
- 3 College-Based EMS Services
- 2 Tribal EMS Services

Nonetheless, the transition from CFAA to NEMHS does present a contrast from a community-based service with primarily local staff to a more generic identity with a mix of local staff and a changing set of faces from other NEMHS bases.

At the Rockport base of NEMHS, two ambulances are budgeted for staffing 24/7 at the Rockport base with a third staffed 12 hours during the daytime. A fourth vehicle is generally present as a back-up (consistent with a loose industry practice of one spare for every 3-5 ambulances in frontline use). A wheelchair van is maintained for transports not requiring an ambulance. With approximately 1,500 9-1-1 calls and 1,000 IFT calls per year, this ambulance availability seems to be more than enough to cover demand (in EMS measurement terms, this is a "Unit Hour Utilization" or UHU of 0.12 – or ambulances in use 12% of their time available for use). This is a fallacy of sorts since the Rockport base's ambulances are often on four-to-five-hour transports to Portland, and once there, may be used for local transfers on occasion. This practice, however, keeps the Rockport fleet from achieving a higher UHU enjoyed by more urban operations.

Picture 1 - NEMHS Rockport Base Garage During Project Inspection – October 25, 2020

When staffing is short and only two trucks are able to be staffed during the day, that is when Brunswick-based resources may be moved north or used for out-of-town interfacility transports. Use of these resources occurs several times a week according to NEMHS leadership and staff interviews.

NEMHS is licensed at the Advanced EMT level, with a permit to Paramedic level, by Maine EMS. This means that it must provide at least one Advanced EMT in the two-person crew responding to every 9-1-1 call. It may also substitute a Paramedic for one or more of those crew who may practice at that more advanced level. It also can provide a "Paramedic Interfacility Transport" or "PIFT" certified Paramedic on inter-facility transports when indicated.

NEMHS has, by town contract, agreed to provide a Paramedic on 9-1-1 calls that are classified by KRCC as likely to require "advanced life support" or "ALS" capabilities. These would be the skills reflected in the table below as Advanced EMT or Paramedic. Skills listed as EMT in the table are generally considered more "basic life support" or "BLS". All three levels of practitioner provide BLS to which Advanced EMT, Paramedic and PIFT Paramedics add ALS appropriate to their licensure and certifications.

Table 2

Who Can Do What When?

BASIC LIFE SUPPORT	BLS/ALS Skills	ADVANCED LIFE SUPPORT	
EMT	**Advanced EMT**	**Paramedic**	
Assists with Meds (OLMC*)	Assists with Meds	Assists with Meds	Albuterol (Breathing)
Assists with Inhaler (OLMC*)	Assists with Inhaler	Assists with Inhaler	Amiodarone (Heart)
CPR	CPR	CPR	Aspirin (Heart)
Oxygen	Oxygen	Oxygen	Atropine (Heart)
Heart Defibrillation (AED)	Heart Defibrillation (AED/Manual)	Heart Defibrillation (AED/Manual)	Calcium Gluconate (Heart)
Glucometer (Glucose Testing)	4 Lead Heart Monitor (Limited)	4 Lead Heart Monitor	Dexamethasone (Breathing)
Splinting	12 Lead Placement	12 Lead Heart Monitor	Dextrose/D10/D50 (Diabetes)
Spinal Motion Restriction	Secure Vein Access (IV)	Secure Airway (Intubation)	Diphenhydramine/Benadryl (Allergy)
Bleeding control (including	Glucometer (Glucose Testing)	Secure Vein Access (IV)	Epinephrine (Heart/Breathing)
Tourniquet and hemostatic agent)	Spinal Motion Restriction	Glucometer (Glucose Testing)	Fentanyl (Pain)
Airway Management (BVM,OPA,	Splinting	Heart Pacing	Glucagon (Diabetes)
NPA)	Laryngal Mask Airway	Heart Cardioversion	Ipatromium Bromide (Breathing)
	Blind Insertion Airway Device	Surgical Procedures (Breathing)	Levophed (Heart/BP)
	Capnography	Splinting	Lidocaine (Pain)
	EZ I/O	Spinal Motion Restriction	Ketamine (Pain)(OLMC*)
Albuterol (Patient's)(OLMC*)		Capnography	Magnesium (Heart, Breathing)
Aspirin 324 mg (Heart)	Aspirin (Heart)	EZ I/O	Metoprolol/Lopressor (Heart)
Oral Glucose (Paste)	Albuterol (Breathing)(OLMC*)	Gastric Tube	Midazolam/Versed (Seizures)
Epinephrine (Auto Injector)	Acetaminophin (Pain)(OLMC*)	Blind Insertion Airway Device	Naloxone/Narcan (Overdose)
Naloxone (Atomized)(Overdose)	Nitroglycerin SL (OLMC*)	Tourniquet and Hemostatic Agent	Nitroglycerin (Heart/Breathing)
Nitroglycerin (Patient's) (OLMC*)	Epinephrine (Auto Injector)	Chest decompression	Nitrous Oxide (Pain)
	Glucagon (Diabetes)		Ondansetron/Zofran (Nausea)
	Naloxone/Narcan	Acetaminophin (Pain)	Sodium Bicarbonate (Heart)
	Dextrose D10/D50	Activated Charcoal (Poison)	Tetracaine (Eye Pain)
	Oral Glucose (Paste)	Adenosine (Heart)	Tranexemic Acid (Bleeding)

*After Consultation with On Line Medical Control

Effective December 1, 2019 (Updated 11/3/2020) ***Courtesy of NorthStar EMS ~ www.fchn.org/NorthStar***

The staffing budget for NEMHS at the Rockport base includes an EMT and a Paramedic for each of the three staffed shifts described above (two 24-hour and one 12-hour) seven days a week. Ideally, this constitutes a staff of mostly full-time personnel with some shifts filled by part-timers or full-timers working over-time. This allows flexibility to staff with less than a Paramedic level when only BLS is required, to staff an extra truck when not otherwise scheduled, to add a PIFT Paramedic for an interfacility transport, and to address staffing challenges when staff call out or leave. Such challenges have been a problem in recent years and are discussed below.

NEMHS' specific contractual staffing agreement is to provide a Paramedic on at least 95% of calls classified as ALS. There is a financial penalty when this does not occur. Table 3 presents an NEMHS report for 2019-2020 demonstrating compliance with this contract provision in all quarters of the year.

Project staff reviewed evidence of patient satisfaction surveying done by NEMHS. This indicated satisfactory reviews when performed.

Table 3

Paramedic Response to Advanced Life Support Trips*

***Contract Requirement:** As measured quarterly, a paramedic will respond to 95% or greater of all Advanced Life Support trips

Camden					Hope					Lincolnville					Rockport					
Month	Total Calls	ALS Calls	Medic	Average	Month	Total Calls	ALS Calls	Medic	Average	Month	Total Calls	ALS Calls	Medic	Average	Month	Total Calls	ALS Calls	Medic	Average	Quarter Average
July '19	89	41	41	100.0%	July '19	7	5	5	100.0%	July '19	14	7	7	100.0%	July '19	37	13	13	100.0%	
Aug '19	70	22	22	100.0%	Aug '19	4	3	3	100.0%	Aug '19	13	7	7	100.0%	Aug '19	49	22	22	100.0%	
Sept '19	90	34	33	97.1%	Sept '19	0	0	0	-	Sept '19	7	4	4	100.0%	Sept '19	35	14	14	100.0%	
Q1	**249**	**97**	**96**	**99.0%**	**Q1**	**11**	**8**	**8**	**100.0%**	**Q1**	**34**	**18**	**18**	**100.0%**	**Q1**	**121**	**49**	**49**	**100.0%**	**99.42%**
Oct '19	92	37	37	100.0%	Oct '19	6	6	6	100.0%	Oct '19	14	7	7	100.0%	Oct '19	25	10	9	90.0%	
Nov '19	64	21	21	100.0%	Nov '19	6	3	3	100.0%	Nov '19	14	10	10	100.0%	Nov '19	40	21	21	100.0%	
Dec '19	68	24	24	100.0%	Dec '19	2	0	0		Dec '19	14	6	6	100.0%	Dec '19	31	25	25	100.0%	
Q2	**224**	**82**	**82**	**100.0%**	**Q2**	**14**	**9**	**9**	**100.0%**	**Q2**	**42**	**23**	**23**	**100.0%**	**Q2**	**96**	**56**	**55**	**98.2%**	**99.41%**
Jan '20	71	29	29	100.0%	Jan '20	8	5	5	100.0%	Jan '20	4	4	4	100.0%	Jan '20	44	23	23	100.0%	
Feb '20	68	26	25	96.2%	Feb '20	4	2	2	100.0%	Feb '20	3	1	1	100.0%	Feb '20	24	8	8	100.0%	
Mar '20	73	31	31	100.0%	Mar '20	7	4	4	100.0%	Mar '20	8	6	6	100.0%	Mar '20	26	14	14	100.0%	
Q3	**212**	**86**	**85**	**98.8%**	**Q2**	**19**	**11**	**11**	**100.0%**	**Q2**	**15**	**11**	**11**	**100.0%**	**Q2**	**94**	**45**	**45**	**100.0%**	**99.35%**
April '20	53	25	24	96.0%	April '20	5	1	1	100.0%	April '20	14	9	9	100.0%	April '20	17	9	9	100.0%	
May '20	42	16	16	100.0%	May '20	5	1	1	100.0%	May '20	20	15	15	100.0%	May '20	23	10	10	100.0%	
June '20	54	23	23	100.0%	June '20	10	5	5	100.0%	June '20	12	7	7	100.0%	June '20	18	7	7	100.0%	
Q4	**149**	**64**	**63**	**98.4%**	**Q4**	**20**	**7**	**7**	**100.0%**	**Q4**	**46**	**31**	**31**	**100.0%**	**Q4**	**58**	**26**	**26**	**100.0%**	**99.22%**
Annual	**834**	**329**	**326**	**99.1%**	**Annual**	**64**	**35**	**35**	**100.0%**	**Annual**	**137**	**83**	**83**	**100.0%**	**Annual**	**369**	**176**	**175**	**99.4%**	**99.36%**

When staffing at any EMS agency is not sufficient to respond at the time a 9-1-1 call is received, the agency staff can request (or an automatic request is triggered by agreement) to have a neighboring ambulance dispatched in a process called mutual aid. Mutual aid agreements describe the circumstances in which aid will be provided, any conditions for that aid, and how it is paid for. The towns and NEMHS participate in a somewhat generic countywide mutual aid agreements, a plan with Union enabling that ambulance to bill for NEMHS ALS assistance when needed, and a mutual aid billing arrangement with the Rockland Fire Department (RFD). Possible over-dependence on mutual aid from RFD was one of the concerns expressed in interviews and is addressed below. NEMHS pays a fee to RFD for mutual aid use and loses its normal revenue on all calls RFD handles, so there is a financial penalty built into decisions to use mutual aid. Neither NEMHS nor RFD feels that the current frequency of mutual aid use is excessive.

The information on NEMHS call performance follows a request to Maine EMS for five years of operational data. A request was also made to NEMHS for data reports that it had supplied to the towns and PBMC, based on various data including that from Maine EMS and KRCC. Maine EMS was extremely helpful in providing raw and report data for this project. Project staff advisors analyzed Maine EMS data, and found inconsistencies in the call volume and response performance data across years that we sought to employ. These appeared to have been caused by transitions in the data system used by Maine EMS as they were implemented by NEMHS and services chosen with which to compare NEMHS. These transitions were not accomplished by all services at the same time.

In addition to these idiosyncrasies, it is easy to get lost in the weeds of data reports, so Project staff present data here which demonstrate the preponderance of their impressions of response performance in the Project area and comparison towns in the most recent

years for which data was complete, reliable and understandable. They found that calendar year 2019 and NEMHS contract years 2019-20 were representative of the entirety of data reviewed. They are the most contemporary without seemingly large impact by the pandemic onset.

Table 4

Maine EMS 2019 Data:
9-1-1 Call Response Time of Incident to Time Ambulance Arrived on Scene
(In Minutes)

Response	Total	Mean Average	90th Percentile
NEMHS to Camden	903	9.4	14.0
NEMHS to Hope	70	16.4	23.0
NEMHS to Lincolnville	165	19.0	27.2
NEMHS to Rockport	423	8.8	14.7
Rockland FD to Rockland	1436	7.2	10.2
Belfast FD to Belfast	1254	11.3	16.0
Belfast FD to Northport	113	17.0	22.75
Belfast FD to Morrill	57	18.1	24.0

Table 4 shows the distribution of the 1,561 9-1-1 calls in 2019 among the four Project towns. Table 4 is representative of the 9-1-1 response time characteristics for the Project four-town response area as well as that of neighboring comparison services, RFD and Belfast Fire Department (BFD), and other comparison service data reviewed for recent years. These other comparison services included Central Lincoln County EMS (approximately 10.9 minutes overall during same period), in the Damariscotta area, Pace Ambulance (approximately 9.8 minutes overall) in the Norway area. Project staff have worked in many similar areas in the state, including NorthStar EMS throughout Franklin County and Winthrop Ambulance Service in a seven town area of Kennebec County, and were struck by no significant performance differences from those.

NEMHS response time to Camden and Rockport, the more urban centers closer to the Rockport base, ranges around nine minutes. This is consistent with RFD and BFD times for responses to their own population centers of seven to eleven minutes.

NEMHS response times to its more distant and rural areas of Hope and Lincolnville are sixteen to nineteen minutes. This compares reasonably with BFD response times (RFD not having significant volume to similar areas) of seventeen to eighteen minutes to two of its more frequent distant rural call areas.

The response times used for comparison were Maine EMS times that EMS crews recorded for time of incident to time that the ambulance arrived on scene. They should not be casually compared with "response times" used in other reports, at risk of not comparing apples to apples. This is because there are also other ways that are commonly used to measure response time performance. For instance, these include

- *"Notified to Arrival"* Time – This is the interval from when the EMS crew was informed by dispatch of the need for response to the time that EMS arrived at the scene. This includes the time it takes for the crew to prepare to respond (e.g. get out of bed at night, dress and get the ambulance started and on its way). This may be more accurate than the times recorded as "time of incident" used in the table and comparison above because it is usually recorded by a dispatcher with a universal time clock rather than an EMT or person on scene estimating the time of incident. One might expect these times to be less than the incident to arrival times reported above, because of delays between the incident occurring and the dispatcher notifying NEMHS of the incident.
- *"Travel to Scene"* Time – This is the interval from the time the crew notifies dispatch that it has left for the scene to the time of its arrival on the scene. It is expected to be less than "*Notified to Arrival"* time because it does not include time required for the crew to get in the ambulance and get it moving.

The following are these times as reported by Maine EMS for 2019 in minutes:

Table 5

NEMHS Response Town	Notified to Arrival Time	Travel to Scene Time
Camden	8.3	7.1
Hope	14.9	13.4
Lincolnville	17.6	15.9
Rockport	7.4	6.2

The primary purpose for mentioning these differences is that there has been a fair amount of discussion about response times leading up to this Project, and Project staff was aware of some apples-to-oranges comparison issues that have existed. This could be, in part, addressed by having consistent language in the NEMHS/town contracts across the board, which was not the case in 2020-2021.

While response times are a practical concern for a community and its leaders, using an EMS agency's performance on response times alone does not equate to the "life-saving" or life-improving capabilities of the modern service. Table 4 introduces another way of looking at response times which is more useful than the mean average response times now being used in Project towns as a measure and upon which to base penalties for

noncompliance by NEMHS. That method is the use of fractile response times. The last column in the table shows these for "90th percentile" responses. For Camden, by way of example, one would read the table to say that 90% of all the 9-1-1 calls in Camden represented in the table were answered in 14.0 minutes or less. This offers a more precise and manageable target for performance review and mitigation of calls exceeding a locally adopted standard (in this example, having an EMS performance review group look at all calls exceeding 14 minutes; or selecting the 95th percentile if 90th percentile still produces an unmanageably large group of calls to review). Even better is reviewing responses to calls for specific patient conditions by as small a geographic zone as possible. In this approach, times to the administration of specific treatment for those conditions is considered along with more precise response times.

Table 6 presents another example of a report made by NEMHS on a regular basis for the Project towns on response times. The original NEMHS/town contract language that governed response time was "total time from when the call is acknowledged by NEMHS to the time NEMHS's ambulance arrives at the incident". The data in Table 6 seems to reflect that this is "travel to scene time." As mentioned above, response time had engendered much discussion on how it is computed in recent time leading up to this Project. NEMHS indicated that, as a result, the Camden/Rockport agreements contained a change to response time reporting which was "notified to arrival" time, while the other two contracts retained the above language. This should be addressed if NEMHS continues service to the towns in the next year.

Table 6

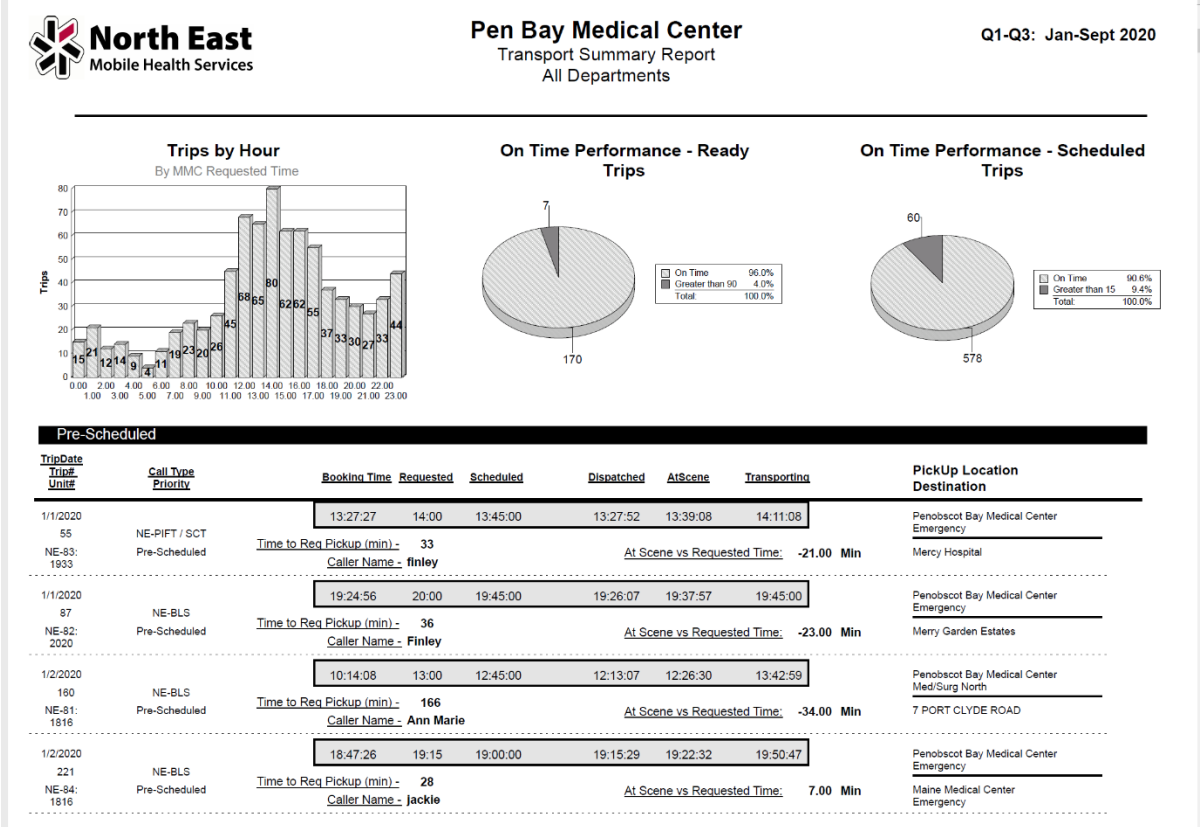
Average Response Time by Town*

***Contract Requirement:** Each town will have an **Average** response time measured quarterly. Fiscal year begins July 1st.

Contractual Time		Contractual Time		Contractual Time		Contractual Time	
Camden: 9 minutes		**Hope: 17 minutes**		**Lincolnville: 19 minutes**		**Rockport: 9 minutes**	
Month	**Ave. Response Time**	**Month**	**Ave. Response Time**	**Month**	**Ave. Response Time**	**Month**	**Ave. Response Time**
July '19	07:33.0	July '19	16:09.0	July '19	15:39.0	July '19	06:23.0
Aug '19	08:04.0	Aug '19	13:30.0	Aug '19	15:40.0	Aug '19	06:04.0
Sept '19	07:27.0	Sept '19	-	Sept '19	20:00.0	Sept '19	07:43.0
Q1	**07:40.0**	**Q1**	**15:11.0**	**Q1**	**16:14.0**	**Q1**	**06:39.0**
Oct '19	07:15.0	Oct '19	11:20.0	Oct '19	13:44.0	Oct '19	06:10.0
Nov '19	08:04.0	Nov '19	14:00.0	Nov '19	18:14.0	Nov '19	06:11.0
Dec '19	07:52.0	Dec '19	17:00.0	Dec '19	19:26.0	Dec '19	06:02.0
Q2	**07:40.0**	**Q2**	**13:17.0**	**Q2**	**17:22.0**	**Q2**	**06:08.0**
Jan '20	07:38.0	Jan '20	15:23.0	Jan '20	15:50.0	Jan '20	06:25.0
Feb '20	07:47.0	Feb '20	13:52.0	Feb '20	16:47.0	Feb '20	06:37.0
Mar '20	07:57.0	Mar '20	14:05.0	Mar '20	16:55.0	Mar '20	05:15.0
Q3	**07:48.0**	**Q3**	**14:35.0**	**Q3**	**16:37.0**	**Q3**	**06:09.0**
April '20	07:20.0	April '20	11:45.0	April '20	15:35.0	April '20	05:35.0
May '20	06:50.0	May '20	12:56.0	May '20	15:46.0	May '20	07:32.0
June '20	07:16.0	June '20	13:13.0	June '20	15:25.0	June '20	06:34.0
Q4	**07:10.0**	**Q4**	**12:47.0**	**Q4**	**15:37.0**	**Q4**	**06:40.0**
Annual	**07:37.0**	**Annual**	**13:50.0**	**Annual**	**16:24.0**	**Annual**	**06:23.0**

Table 7 presents a standard report NEMHS indicates it has provided PBMC for its interfacility transport (IFT) support despite its formal contract having lapsed in 2018. The report indicates compliance with provisions made in the earlier contract to respond a transport crew to PBMC within 15 minutes of the agreed upon time for a "scheduled" call (in this 9-month report 91% of the time), and within 90 minutes for a "ready trip" (an unscheduled IFT request (in this report 96% of the time). The report also provides a list of the IFTs accomplished during the period. When asked for data documenting the IFT activity from the PBMC point of view, an IFT call log similar to NEMHS' list of calls was presented, but no aggregated or analyzed data were available. This call log included calls that NEMHS was not able to make and presented insights into such events that supported interview accounts by PBMC ED staff of the types of difficulties encountered in arranging occasional IFTs.

Table 7



North East Mobile Health Services

Pen Bay Medical Center
Transport Summary Report
All Departments

Q1-Q3: Jan-Sept 2020

Trips by Hour
By MMC Requested Time

On Time Performance - Ready Trips

On Time Performance - Scheduled Trips

Pre-Scheduled

TripDate / Trip# / Unit#	Call Type / Priority	Booking Time	Requested	Scheduled	Dispatched	AtScene	Transporting	PickUp Location / Destination
1/1/2020 / 55 / NE-83: 1933	NE-PIFT / SCT / Pre-Scheduled	13:27:27	14:00	13:45:00	13:27:52	13:39:08	14:11:08	Penobscot Bay Medical Center Emergency / Mercy Hospital
		Time to Req Pickup (min) - 33			At Scene vs Requested Time: -21.00 Min			
		Caller Name - finley						
1/1/2020 / 87 / NE-82: 2020	NE-BLS / Pre-Scheduled	19:24:56	20:00	19:45:00	19:26:07	19:37:57	19:45:00	Penobscot Bay Medical Center Emergency / Merry Garden Estates
		Time to Req Pickup (min) - 36			At Scene vs Requested Time: -23.00 Min			
		Caller Name - Finley						
1/2/2020 / 160 / NE-81: 1816	NE-BLS / Pre-Scheduled	10:14:08	13:00	12:45:00	12:13:07	12:26:30	13:42:59	Penobscot Bay Medical Center Med/Surg North / 7 PORT CLYDE ROAD
		Time to Req Pickup (min) - 166			At Scene vs Requested Time: -34.00 Min			
		Caller Name - Ann Marie						
1/2/2020 / 221 / NE-84: 1816	NE-BLS / Pre-Scheduled	18:47:26	19:15	19:00:00	19:15:29	19:22:32	19:50:47	Penobscot Bay Medical Center Emergency / Maine Medical Center Emergency
		Time to Req Pickup (min) - 28			At Scene vs Requested Time: 7.00 Min			
		Caller Name - jackie						

Maine EMS data report "response time" for IFT calls. These are not significant indicators in and of themselves because there is no definition of whether these involve "ready now," "scheduled," or other types of calls. These 2018-19 response times range from 15 minutes for PACE and Central Lincoln County services, and 15.7 minutes for Belfast Fire, to 18.7 for NEMHS. Emergency department staff who work at both Miles Hospital, served by Central Lincoln County, and PBMC favor the former's IFT performance during interviews over NEMHS' despite the small difference in times reported here.

Tables 8 and 9 describe the volume of NEMHS' IFT activity from PBMC to other facilities in 2019 according to Maine EMS data. Table 10 summarizes these, with Table 4's data on 9-1-1 calls, totaling the 2,606 calls that Maine EMS data indicate NEMHS responded to in 2019.

Table 8

NEMHS IFTs from PBMC to Hospitals	2019
Maine Medical Center	295
Other Facility	52
Waldo	32
Eastern Maine Medical Center	20
Maine General Augusta	18
Lincoln Health	15
Boston Area Facilities	14
VA Togus	14
Central Maine Medical Center	13
Acadia Hospital	8
New England Rehab. Center	7
Mid-Coast Hospital	5
St. Mary's Hospital	5
Dorothea Dix Psych. Center	2
Total	**500**

Table 9

NEMHS IFTs from PBMC to Nursing/Rehab. Homes	2019
Sussman House	116
Windward Gardens	113
Penn Bay	105
Woodlands	72
Knox Center	55
The Garden	33
Bella Point	12
Quarry Hill	10
Crawford Commons	8
Harbor Hill	7
Country Manner	6
Other	8
Total	**545**

Table 10

Total NEMHS Calls by 9-1-1 and IFT Origin	**2019**
9-1-1 Calls to Camden, Hope, Lincolnville and Rockport	1,561
IFT Calls from PBMC to Other Facilities	1,045
Total NEMHS Calls in Project Towns and PBMC	**2,606**

VI. North East's Other Capabilities and Performance

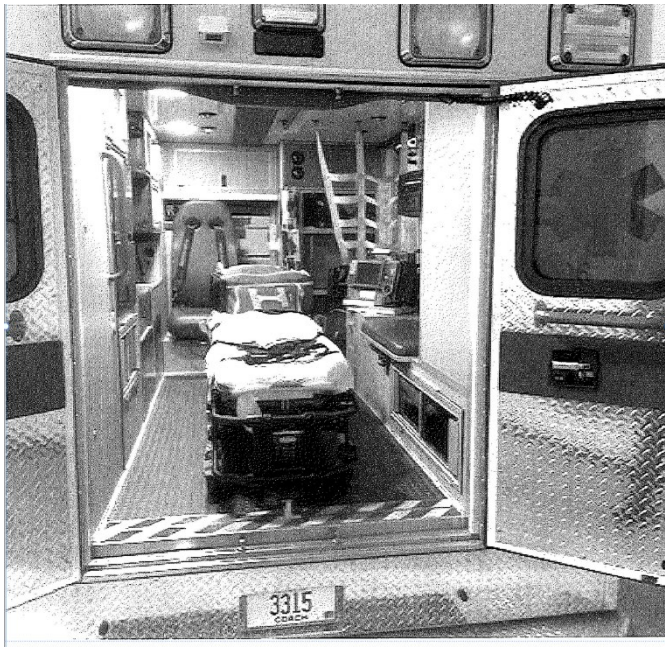
The NEMHS Rockport base was inspected and formal interviews of leadership and a sampling of staff carried out in October, 2020 by Mike Senecal. Additional staff input was solicited informally at other times during the Project.

The inspection found the vehicles and garage space seen in Picture 1, above. Vehicles, garaging facility, and equipment and supplies aboard the vehicles and in storage were found to be clean, operable, well-organized, contemporary and exceeding the requirements of Maine EMS, the State licensing agency. Pictures 1 to 5 reflect this for the EMS-uninitiated. An electronic EMS manager application is used for ambulance and equipment inspections. Electronic and other records of routine vehicle, equipment and supply inventorying and inspection were consistent with these findings with minimal non-compliance noted. Interviews were also consistent with these findings, though indicated that in past periods of absence of a base manager, or ineffectiveness of base managers, compliance with inventorying and inspection procedures varied with crews on duty. By all accounts, this has improved under the current base manager.

The base facility is contemporary construction for the purpose it serves, though lacking dedicated kitchen/dining, bathroom/shower, equipment cleaning, and laundry facilities which would bring these to a more reasonable base of operations for busy crews, and easier to comply with standards of cleaning and disinfection of equipment, uniforms, and other necessities.

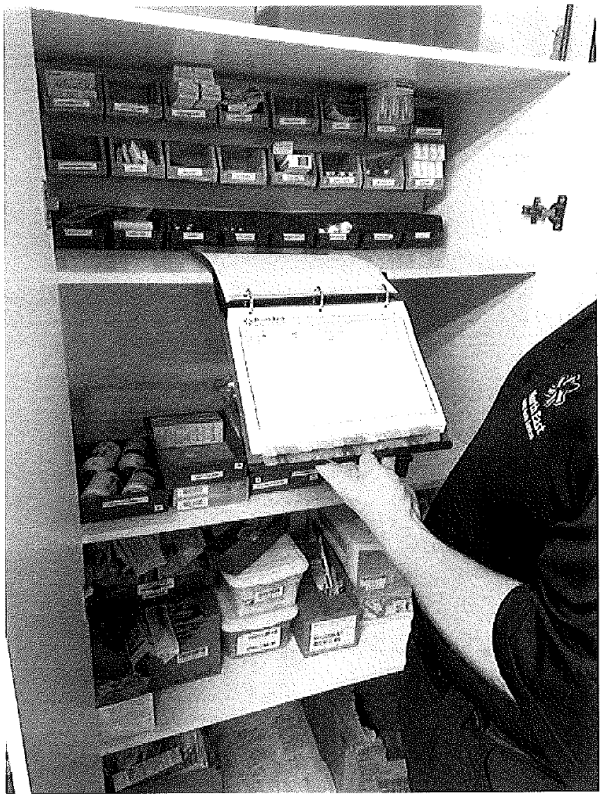
Leadership interviews reflected plans to update these aspects of the base prior to the pandemic, and a renewed intention to do so. Important to a number of supervisory-centric criticisms in interviews mentioned in this section, leadership has stated its intent to maintain an effective base manager as a high priority and to add shift supervisory leaders to help make this position more manageable.

Picture 2 – Ambulance Compartment with Patient Extrication Equipment



Picture 3 – Ambulance from Rear Loading Doors

Picture 4 – Ambulance Kits Storage



Picture 5 – Small Supplies Storage and Log

North East Mobile Health Services formed as an enterprise under Charles McCarthy and his partner, Dennis Brockway in 1999. They were also leaders in the development of Capital Ambulance which originated in the Augusta area, moved its headquarters to Bangor and is now Northern Light Medical Transport, affiliated with the health care system of the same name. The operating, licensure, and character history, records and reputations of these two major EMS operations, and the nature of the involvement of its principals in state system development all lend the current NEMHS operation a degree of credibility as a service operator. Therefore, the underpinnings of an ambulance service in jeopardy (the usual focus of an ICDS process) are not in question, nor did the proprietary aspects of NEMHS' governance, financial, and other corporate aspects demand attention. Operational guidelines and procedures, training and education requirements, safety and other practices have been in place without challenge by Maine EMS or regional quality improvement entities in the two decades of its history. These were not, therefore, considered to be necessary to explore in detail beyond surface inspection and interview verification by leadership and staff. Issues that were revealed are indicated below.

System status management is a concept employed in EMS to anticipate needs for EMS response and to move and stage ambulances accordingly. This is more widely deployed and better understood in larger urban/suburban response areas than in more rural areas with fewer EMS resources. While NEMHS does not utilize such a system formally, its dispatch and internal communications center, MedComm (which also dispatches LifeFlight and other ambulance services), does have computer-aided vehicle location, communications and deployment tools. As mentioned previously, moving vehicles and crews between bases in Brunswick and Rockport is a frequent occurrence. Related issues include crews unfamiliar with the Rockport base response area responding to 9-1-1 calls, and crews transporting patients to Portland being caught up in other calls in that area rather than returning to Rockport immediately. Otherwise, MedComm seems to serve this informal system management system adequately.

Communications are a persistent issue in three areas already reflected or reflected below:

1. System Radio and Other Communication: NEMHS uses the MedComm center in Bangor for most of its dispatching needs. It tries to integrate this system with the KRCC dispatch system in Knox County and with an "I am Responding" application commonly used by public safety in the County to track the status (availability and location) of emergency units. This does not always work well. NEMHS staff are frustrated that KRCC won't call MedComm when it dispatches an NEMHS unit, and Knox County staff and some departments don't feel that NEMHS uses the "I am Responding" application as it is intended. The importance of such coordination belies the fact that this has been going on for several years.
2. Leadership Communications: There is a lack of routine communication among town, fire department, and PBMC leaders and NEMHS. NEMHS staff cite a weak town attendance at EMS Performance Review Advisory Committee process meetings that should be a venue for discussion, problem-solving, and updating. They show their efforts at routine reporting which evidences contract compliance and willingness to discuss and resolve issues. Some town and PBMC leaders

characterize NEMHS as being weak on responding to problems and follow-through on promised initiatives. Other towns' officials have indicated that NEMHS leadership has been accessible and reliable on follow-through. NEMHS officials seek a consistent point of contact in PBMC administration as well as that which it has in the emergency department. PBMC emergency department leadership seek a more routinely accessible and present point of contact at the Rockport NEMHS base.

3. Intra-service Communications – The communication issues cited in interviews below.

Finally, with issues raised about staff performance during interviews with some fire and PBMC staff, quality improvement (QI) was reviewed. We were told by leadership that all service studies for Rockport Division have focused on response time performance (and are described above). There have been studies of individual performance. They added that NEMHS has just signed into a second year of an agreement with APEMS for training. This year they added into the agreement skills verification, that will make it mandatory for all licensed EMS personnel to pass an independent, third party skills verification.

Interviews with NEMHS staff consisted of formal sit-downs with on-duty and other staff designated by NEMHS and some informal conversations with other current staff. While staffing issues were often mentioned as a source of response time and mutual-aid-overuse concerns mentioned by fire service officials interviewed, they were not reflected in concerns about pay levels or working conditions of those interviewed. Yet a common refrain from staff was the loss of "the best paramedics" to fire services in the state.

Common themes from NEMHS staff interviews were:

- Feelings of isolation from the rest of NEMHS and being treated as second class considerations, especially feeling that base managers were actually or effectively absent in communicating for them with upper management in Scarborough.
- Lapses in leadership providing performance, administrative and training oversight. Many felt that crews had been left to govern and make decisions for themselves that should have been a base manager's job.
- A mix of receptiveness from staff at PBMC emergency department, making for uncertain relationships for some NEMHS staff.
- Morale suffers with an absence of local leadership and regular communication from Scarborough. There has been a feeling over a few years of "who speaks for us and our base's needs?"
- Training offerings were characterized by most as good up until the pandemic began.
- Constant pressure to "be here right away" for interfacility transports from PBMC.
- Getting stuck in the Portland/Maine Medical Center (MMC) "vortex" when on an IFT to MMC is frustrating when crews feel urgency to be available in Rockport.
- A negative working environment with some fire chiefs on scenes and as a result of their comments in the press and at town meetings.

- Otherwise, there seems to be a generally a good working relationship with most fire and law enforcement staff on scenes, and with long-term facility staff in most situations. That said, when there is hostility, it seems to be passed from certain fire officers down through the ranks.
- New equipment availability requests sometimes not answered.
- Many of the lapses cited above were also mentioned as having improved with the current base manager.

Finally, interviews with area public safety responders, town officials, businesspersons, and nursing/convalescent health care facilities staff added the following:

- Those not involved in public safety or town government generally had neutral or positive attitudes about NEMHS as their ambulance service. Some mentioned missing the familiar faces of, and a community-based service like CFAA, but also acknowledged financial and management issues to which that particular service had subjected the community in terms of.
- Those involved in public safety or town government, more so in Camden and Rockport than Hope and Lincolnville, had general impressions that developing a fire-based EMS agency, perhaps regionally, would be the right direction in the long run. Again, there was a positive attitude expressed toward a community-based service as opposed to a statewide service.
- There were many criticisms expressed by fire service and PBMC staff about individual NEMHS crew members and their performance, readiness for the work involved, knowledge of the response area and its towns and people. Some of this was directly observed and some second-hand accounts, so it was difficult to judge how pervasive these impressions were. It seems that many stories were facilitated by a few because of the consistency of the accounts. No accounts rose to the level of local, regional, or Maine EMS attention to our knowledge.
- Local health care facility staff expressed primarily positive relationships with NEMHS staff.

VII. Camden-Rockport-PBMC: Options to Meet Community Needs for an Agile, Responsive EMS Resource

Following the evaluative work described above, the Project Steering Group assessed the information available and made some initial findings from which options could be developed. With those findings presented, staff analyzed these and all information gathered to date, and took the NEMHS organization and other resources in the four town Project area as profiled in the previous two sections, and analyzed their strengths and weaknesses as well as their opportunities and challenges (an informal "SWOC analysis"). This information enabled staff to develop an initial set of options for the Steering Group to consider.

What follows are:

- The Steering Group/staff findings,

- The staff SWOC analysis,
- The options initially considered,
- The description of the option selected and the process by which it was considered by Town and PBMC decision-makers,
- The resulting NEMHS contract provisions sought by the Steering Group, and
- The draft contracts offered by NEMHS following discussions about the provisions wanted by the Steering Group.

The significant ***findings*** by the Steering Group included:

- The evaluation process response-related data analysis did not uncover issues with NEMHS performance in meeting 9-1-1 response expectations that required immediate or major intervention. An organized first responder capability could be beneficial, particularly in outlying areas, but efforts to implement this do not seem to have succeeded. Anecdotal interview accounts of issues with NEMHS personnel behavior, attitudes, patient care, communications practices, and readiness on calls were encountered but seemed not to rise to regional EMS attention for intervention. Those reporting such issues attributed them to a lack of consistent supervision in recent years. The preponderance of interview input indicated generally reasonable performance by NEMHS staff on calls.

- Issues with IFT performance were difficult to evaluate beyond the anecdotal input from interviews but seemed to be similar to those experienced in other areas of the state. Potential worsening of this situation by pandemic considerations and patient movement within health systems further clouded this aspect of the operation. Aggregating IFT data collected in a log in the emergency department would be useful. NEMHS officials would like a more defined and contemporary set of expectations by which to operate since the one formal contract expired in 2018. They seek to enhance a communications channel in administration as well as that for day-to-day operations with emergency department staff.

- Interviews with Hospital personnel consistently reflected frustration with the process for securing IFT service from NEMHS through MedComm, concerns about inconsistent patient care and communications from the field for patients brought by NEMHS crews to the Hospital, and a consistent sentiment that Rockland Fire and other towns' crews were "professional" and NEMHS crews were less so. This was frequently attributed to lack of base supervision and use of transient employees and crews from other NEMHS bases. It was also frequently noted that in the first years after NEMHS started 9-1-1 service, base supervisors made themselves frequently available at check-in rounds in the ED and at times when IFT demands were high to manage resources. This has eroded in the past few years. A similar effect was noted in reported NEMHS personnel relationships with fire service personnel over the years. Hospital staff with emergency department responsibility uniformly said that they would welcome NEMHS crews in the ER to help or train between calls.

- Interviews with PBMC officials generally indicated that hospital investment in its own EMS capability for IFT, while considered in a meeting process with another Maine Health system hospital-based ambulance service, does not appear to be an option in the current health system reimbursement and pandemic environments.

- The degree to which NEMHS meets its contractual and other service commitments is subject to accountability issues inherent in the terms of the existing contracts. It has met those terms according to response time and staffing reports provided to the Towns periodically. Renewed agreement about those terms; more frequent and consistent meetings for performance reporting and discussion among the Towns, Hospital and NEMHS; and a reliable process for issue-reporting and resolution would be beneficial. Response time reporting should be based on dispatch to at scene time by KRCC and used in contracts, but additional response measures such as fractile time reporting should be added.

- There is consistent anecdotal evidence from interviews that the lack of a consistent and sustained supervisory presence at the NEMHS base in Rockport over a period of years has impaired communications with hospital and town personnel. This may have contributed to additional anecdotal reports of issues with NEMHS personnel performance and service response performance as well as apparent lack of effectiveness in resolving at least some of them. Substituting in NEMHS leadership staff at the base on a transient basis seems to have been an inadequate solution for assuring routine communication and trust among stakeholders and clinical and operational oversight of field staff. NEMHS intentions to have levels of base management and shift supervisory staff should be carried out.

- There is consistent anecdotal evidence from the interview process that NEMHS experienced problems with filling staffing vacancies at times. This was often mentioned in relation to concerns about meeting response time expectations and dependence on Rockland Fire EMS mutual aid. Over a two-year period to mid-2020, Rockland Fire reported a mutual aid rate for the NEMHS response area of just under once a week. Again anecdotally, these issues have become less apparent, and Rockland Fire is less concerned about mutual aid frequency than a year or so ago. KRCC staff noted no mutual aid issues when asked.

- There are three tensions involved in the background of the Project:
    - One is naturally between the Hospital and the Towns. This is not hostile, just practical, and both realize they are representing essentially the same patient interests. It is simply that 9-1-1 response and IFT response "compete" for the same ambulance resources.

    - A second tension is between the general competition between fire service and private service for provision of EMS. NEMHS is a private service EMS, and fire service EMS is the method in use in neighboring Rockland. Generally, in this country, neither has been proven superior to the other.

An argument has been made publicly for developing fire service EMS in the four-town Project area as a way to address both fire and EMS needs.

- The third tension is between the smaller Towns and the larger Towns in the Project, and goes beyond EMS provision into any area in which they consider joint provision of a service to their citizens and, among other things, is a perceived ability to afford a service. The interview process revealed more satisfaction with maintaining the NEMHS provision of EMS in the small towns than in the large ones where the possibility of developing a new fire-EMS capability seems to potentially solve fire and EMS provision issues in one package. It also leads to less patience with any issue involving NEMHS.

The staff's informal assessment of strengths, weaknesses, opportunities, and challenges ("SWOC") of NEMHS and other EMS system resources in the four-town Project area include:

- Strengths:
  - NEMHS is a large service with deep staff, vehicle, financial and other operational resources making it a relatively stable agency with which to contract for service, as well as agile in meeting demand fluctuations.
  - The overall ability of NEMHS to meet contractual obligations has been positively demonstrated and it is willing to enter another contract without significant increase in cost to the towns and, possibly, PBMC.
  - There is a successful fire-based EMS model in Rockland that offers potential operational options in the future by way of example or partnership.
  - Camden Fire officials and NEMHS officials offered operational options for consideration in the future. All of the suggestions fell within known and generally acceptable practices in the EMS field.
  - There has been an unfulfilled potential for a cooperative, four-town first response initiative based in the fire departments and significantly supported by NEMHS (e.g. medical direction, incidentals resupply, and training).
  - There is a new EMS specialty physician at PBMC with responsibility for EMS liaison.
  - There is PBMC emergency department receptiveness to a closer relationship with NEMHS local leadership and staff.

- Weaknesses:
  - The lack of a contractual or other set of mutual expectations between NEMHS and PBMC.
  - Inconsistent understanding and use of the performance measurement components of the NEMHS/town contracts, and dependence on response-time measurement as one of two sole indicators.

- Lack of consistent NEMHS base leadership in Rockport over a multi-year period.
- Negative relationships toward NEMHS responders on scenes and in other settings by some fire officials and their staff.
- Communications challenges on the part of NEMHS officials.
- Failed continuity of EMS Performance Advisory Committee and other routine interactions between town and NEMHS, and PBMC and NEMHS officials.

- Opportunities:
  - After years of being an unfulfilled consideration, creating a first response capability is a reasonable option. Local fire and law enforcement staff have completed EMT training and may be resources to call upon. NEMHS remains supportive of helping to implement this under a cooperative fire-service model. This will enhance opportunities to consider other fire-based EMS options in the future.
  - Rewriting an NEMHS/town contract addressing many of the issues cited in this report can improve them at little or no extra cost.
  - NEMHS has offered contract extensions for the next year or two without significant cost increase.
  - There are realistic alternative proposals for improving EMS provision in the future as offered by fire and NEMHS officials.
  - Models offered by Rockland Fire EMS, Brewer Fire/Northern Light Medical Transport, and Waterville Fire /Delta Ambulance for consideration.

- Challenges:
  - The new contract period begins shortly, on July 1, 2021, limiting implementation of options requiring a longer planning and start-up phase.
  - Many options presented for improving EMS system response involve significant expense increases and require further study, thus limiting their utility this year.
  - The pandemic continues to present operational and financial uncertainty for towns, EMS, and hospitals. This makes it an additionally difficult time to consider wholesale changes in EMS coverage.
  - Strained relationships between fire officials in some of the towns and NEMHS leaders.
  - The costs cited to date of significant changes in how EMS is provided in the area.

Ten initial operational options, **in six general categories**, for 9-1-1 and interfacility transport coverage after June 30, 2021 were drafted for, and considered by, the Steering Group. These were derived from staff team experience with operational models in other, similar settings and considering proposals requested and received from NEMHS and local fire service professionals. Project staff assured confidentiality of the details of any

such proposal, and the details below do not provide any information other than those previously presented in public by others.

Details of the options considered by the Steering Group, such as pros and cons considered, are displayed in Appendix A.

The costs associated with each option are magnitude estimates only. The current total contract cost for the Towns is, per NEMHS, $298,997 plus a .5% CPI boost for 2020-2021, or $300,492. There is no current cost to the Hospital.

The options for 2021 to 2022 (or 2023) that were discussed fell into the following six general categories with ten total options. The costs attached to each were a combination of staff estimates and comparison with information proposed by NEMHS or fire officials in their proposed solutions. These costs were revised as the options were considered, but remained general estimates of anticipated expenses and revenue by Project staff. In Option 2.0, the cost estimate for the first response unit changed significantly in later stages of consideration as the towns felt that they could individually supplant some of the costs estimated. The options considered were:

- **1.0 Status Quo** – Essentially just renew the NEMHS contracts as the sole provider for 9-1-1 with the Towns and IFT with the Hospital. $311,000. This figure includes a 3.5% CPI-based estimate from NEMHS which may be negotiated.

- **2.0 NEMHS Primary Provider with Fire-Based First Response, Service Improvements and Regional Planning Initiative** – Town and Hospital contracts would be revised to include contemporary performance accountability and issue resolution measures, base supervision assurance, and other improvements indicated by the evaluation. A fire-based first response capability would be developed in cooperation with NEMHS and the four Towns' fire departments. This would enhance response time performance and staffing availability at a cost commensurate with the modest indicated need, as well as a foundation for further fire-based EMS development if that becomes indicated. The contract may extend for two years to enable a planning process to explore regionalization of EMS service to enhance efficiency and effectiveness of EMS and fire response capabilities. General magnitude of cost estimate: $350,000 - $400,000 ($311,000 for NEMHS contract plus first response start-up and regionalization planning initiative costs). This includes an estimate for the first response and planning initiatives which need to be refined before going to budget decision-making.

- **3.1-3.3 NEMHS Sole Provider with Enhanced Crew Coverage** – Continue NEMHS contracts with improvements discussed in 2.0, and fund increased pay for NEMHS staff to be competitive, fund an additional 24/7 ambulance coverage, or fund both. General magnitude of cost $.85 million to $1.4 million ($311,000 of NEMHS contract cost plus additional expenses) depending on solution selected.

- **4.1-4.2 Fire-Based Sole Provider for 9-1-1 and IFT** – Start up and operate an EMS unit from either Rockland Fire/EMS or Camden Fire to cover 9-1-1 and IFT response. Ambulances would be maintained in Camden and West Rockport stations. Crews would be mixed departments depending on option selected. $1.2 million start-up (largely capital) costs and $1.2 million annual operating costs. Cost could be somewhat less if operated from Rockland. Revenue from all calls is included as a deduction from costs cited.

- **5.1-5.2 Fire-Based 9-1-1 EMS/NEMHS Based IFT** – Continue to operate IFT as a NEMHS service. Start up and operate 9-1-1 response as a fire-based service from either Rockland Fire/EMS or Camden Fire. Ambulances would be maintained in Camden and West Rockport stations. Crews would be mixed departments depending on option selected. $600,000 start-up (largely capital) costs and just under $1 million annual operating costs. This is cost after revenue for 9-1-1 calls deducted. Cost could be somewhat less if operated from Rockland.

- **6.0 Mixed NEMHS and Fire-Based Response (and Possibly Hospital Based Participation) –** Multiple options possible using a model employed by Brewer Fire and Northern Light Medical Transport for several years and more recently instituted by Waterville Fire and Delta Ambulance. This would have one or more agency providing the vehicles, and one or more agency providing the staff (for example, a fire/EMS agency driver and a NEMHS paramedic). Cost estimates vary with exact model selected and whether used for 9-1-1 response only or for both 9-1-1 and IFT.

The Steering Group made the following determinations and option selection:

- Rejected option 1.0 as unresponsive to issues made evident by the Project evaluation. This would ignore legitimate concerns revealed by the Project evaluation.

- Chose not to pursue options 3.1-3.3 at this time as their cost did not seem justified by the findings of the evaluation as to the problems potentially addressed (NEMHS staff pay and number of units covering). The response time data did not present the picture of a problem that necessitated or would be impacted by a sweeping staff pay increase or the addition of another 24/7 staffed ambulance.

- Chose not to immediately pursue options 4.1-6.0 because:
    - they would be unlikely to be successfully approved and implemented by July 1, particularly under the current process limitations imposed on town budget approval functions and impacting the provision of EMS and Hospital services under the pandemic,

    - they may involve a magnitude of costs not found to be merited by the findings of the Project evaluation (e.g. response time data) and difficult to explain and justify to decision-makers including taxpayers, and

- some of the options involve components targeting improvement of fire-response readiness not able to be addressed by the Project.

- Chose to pursue option 2.0, referring options 4.1-6.0 to the regionalization planning process integral to that option, because:
  - It most directly addresses the issues cited by the evaluation as accountability/supervision/response/communication problems at a cost commensurate with those issues (for example, subject to negotiation with NEMHS most issues may be addressed at minimal contractual cost; also, since response time for 9-1-1 calls does not appear to be a critical problem, creating a fire-based first response capability able to provide basic life support a couple to several minutes before ambulance arrival (depending on location and circumstances) and to provide extra hands in some situations, is justifiable at the cost anticipated.

  - It establishes a foundation for further fire-based EMS development (drawing on local personnel already recently trained) if elected following the regionalization planning process, and

  - It assures continuity and improvement of EMS service during a period adequately long to consider alternative regional models of 9-1-1 and IFT response provision.

- Following an analysis of different ways of apportioning costs of Option 2.0 to the towns, the Steering Group selected to continue using the population-based apportionment of costs for the NEMHS contract, for the regionalization planning project and for the shared administrative costs of the first response unit start-up costs. Costs of call-pay and equipping the first response for responders would be individually budgeted and managed by the towns.

- The financial impact of this option for the towns would be:
  - A .6% increase for the NEMHS contract for 2021-22 based on the New England Consumer Price Index,
  - A population apportioned split of $20,000 for the regional planning initiative,
  - A population apportioned split of $1,200 for the first responder unit administrative costs.

Table 11

Town	2010 Population	2010 Population %	2019-20 NEMHS Contract	2020-21 NEMHS Contract	2021-22 NEMHS Contract	2021-22 Regionalization Plan Initiative	2021-22 1st Responder Admin. Costs
Camden	4,851	41%	$122,066	$123,202	$123,941	$8,200	$492
Rockport	3,330	28%	$83,810	$84,138	$84,643	$5,600	$336
Lincolnville	2,164	18%	$54,463	$54,089	$54,413	$3,600	$216
Hope	1,536	13%	$38,658	$39,064	$39,298	$2,600	$156
Total	11,880	100%	$298,997	$300,492	$302,295	$20,000	$1,200

The Steering Group chose to utilize a select board/town referendum process for decision-making on enacting the option selected. This was consistent with annual planning and budgeting processes in the towns under the pandemic restrictions on public meetings. Informational meetings were held virtually on this subject for the Camden select board, Rockport/Lincolnville/Hope select boards, and again separately for the Hope select board and budget committee. The Rockport select board also hosted an informational session attended by Project staff on the contract it would enter with NEMHS. All sessions were open to the public and were well attended, including by town fire and committee officials.

Contract provisions were drafted by staff and the Steering Group once the informational meetings were held and the option presented received no objections. The Steering Group's desired contract provisions were discussed with NEMHS and a final set conveyed to NEMHS (see Appendix B for this document). NEMHS officials then drafted a contract which was discussed with staff and then the Steering Group. A final draft contract for each town was discussed by staff and NEMHS officials and then presented to the towns. These are found in Appendix C. The Steering Group agreed that at least one town attorney from Camden and/or Rockport would review the contract provisions. Further contract discussions would be held between NEMHS and the towns directly.

There was no new PBMC/NEMHS contract developed in the Project. However, a relationship was established between the PBMC EMS liaison, Dr. Skinner, and the NEMHS CEO, Mr. Russell. They held an initial meeting with further ongoing discussions planned to address the findings of this Project.

Appendix A. Original Options Considered by Steering Group

Addendum: Original Options Discussed (From 12/10 Steering Group Meeting)

Option Development

- ***1.0 NEMHS Sole Provider Status Quo***
  - Baseline Current (2019 - 2020) Service Level/Cost:
    - Cost: $298,997 + .5% CPI = $300,492 (Towns Subsidy)
  - 1.0 Status Quo (2021 – 2022) Service Level/Cost:
    - Cost: $300,492 + 3.5% CPI = **$311,009**
- ***2.0 NEMHS Sole Provider – Strong Interview Based Improvements***
    - Cost: $300,492 + 3.5% CPI = **$311,009 ($336,009** with First Response Option) Annual Operating
      - Option: First Response Incentives: Total - $25,000
        - ***This is only an example.*** If first response is chosen to be developed, it will need to blend with current FD procedures and payment schemes.
        - Call pay: 1,000 Responses @ $15 = $15,000
        - Equipment/Supplies: 25 Responders @ $100 = $2,500
        - Insurance, training, miscellaneous: $7,500
    - Improvements:
      - Accountability:
        - Response Time and Other Contractual and Reporting Provisions
        - Town and FD Coordination/Performance Review Meetings
        - Supervisor/PBMC Staff Routine Meetings
        - First Response Capability Development
      - NEMHS Base Supervision
        - Position Continuity is a Priority
        - PI/QI Measures to be Utilized
      - NEMHS Staff Downtime Utilization
        - Integrate with PBMC ED/Other On-Site
        - Operate a Truck from Camden FD
      - Continue Regional Approach Assessment/Planning

        - Cost of Facilitator/Fire Service SME/EMS SME?
    - Pros/Cons:
        - Pros
            - Cost Stability
            - Least Complicated/Intrusive Under COVID Challenge
            - With First Response Option, Begins to Integrate FDs into EMS Response Formally
            - Potential to Address Issues Raised
            - Possible Impact on Response Times
            - Interim Path to Considering Regional/FD Options
        - Cons
            - May Not Address All Staffing Issues Raised by Some
            - May Not Address Unit Availability Issue Raised by Some
            - Doesn't Otherwise Address FD Model for EMS

- ***3.0 NEMHS Sole Provider - Mixed Interview Based Changes***
    - 3.1 Increased Coverage by 24/7 Unit (no base pay increase)
        - Cost: $300,492 + $475,000 = **$775,492** Annual Operating
    - 3.2 Increased Base Pay (no increased 24/7 coverage)
        - Cost: $300,492 + $205,000 = **$505,492** Annual Operating
    - 3.3 Increased Coverage by 24/7 Unit and Increased Base Pay
        - Cost: $300,492 + $755,000 = **$1,055,492** Annual Operating

        - Pros/Cons
            - Pros
                - May Address Staffing Issues Raised by Some
                - May Address Unit Availability Raised by Some
                - May be Stronger Interim Measure Than 2.0
            - Cons
                - Additional Unit Without Additional Pay May Not Attract Sufficient Staff
                - Competition for Local Staff
                - Data Consistent With Solution?

        - Ability to Explain Solution

- ***4.0 Fire-Based EMS Sole – 911 and IFT***
    - 4.1 Camden FD Hub and Rockport Station
        - Cost: $1,185,000 Capital Start-up; $1,220,000 Annual Operating
    - 4.2 Rockland FD Hub and Spoke
        - Cost: Less than 4.1

        - Pros/Cons
            - Pros
                - Local "Ownership"
                - Possible Response Time Improvement
                - Possible Assistance to Fire Coverage
                - Regional Solutions Are Potentially More Effective and Efficient – Rockland or Countywide Approach is Worth Further Study
                - Rockland Hub Plan Brings Experienced Fire-EMS Organization
            - Cons
                - Implementation Difficult in Current Time-Frame and Under COVID Environment Uncertainty
                - Competition for Local Staff
                - Data Consistent With Solution?
                - Ability to Explain Solution
                - Local Hub Lacks Fire-EMS Developmental Experience

- ***5.0 Fire-Based 911 EMS/NEMHS Based IFT***
    - 5.1 Camden FD Hub and Rockport Station
        - Cost: $600,000 Capital Start-up; $990,000 Annual Operating
    - 5.2 Rockland FD Hub and Spoke
        - Cost: Less than 5.1

        - Pros/Cons
            - Pros
                - Local "Ownership" for 911 Response

        - Possible Response Time Improvement
        - Possible Assistance to Fire Coverage
        - Regional Solutions Are Potentially More Effective and Efficient – Rockland or Countywide Approach is Worth Further Study
        - Rockland Hub Plan Brings Experienced Fire-EMS Organization

    - Cons
        - Implementation Difficult in Current Timeframe and Under COVID Environment Uncertainty
        - Competition for Local Staff Even More so Than 4.0
        - Data Consistent with Solution?
        - Ability of NEMHS to Attract Staff for Interfacility Only Work
        - Local Hub Lacks Fire-EMS Developmental Experience

- ***6.0 Mixed NEMHS and Fire-Based/Possible Future Transition***
    - Cost: Too vague to be estimated at this time. Many options.

    - Pros/Cons
        - Pros
            - Brewer/Waterville Mixed Approaches Have "Sold" in Other Communities
            - Local "Ownership" Introduced
            - Possible Assistance to Fire Coverage
            - Regional Solutions Are Potentially More Effective and Efficient – Rockland or Countywide Approach is Worth Further Study
        - Cons
            - Implementation Difficult in Current Time-Frame and Under COVID Environment Uncertainty

- Data Consistent With Solution?

Appendix B – Steering Group Approved Provisions for a New NMHS Contract


Final Contract Gen. Prov.s 3-25-21.pdf

Appendix C – Draft Town Contracts Delivered by NEMHS


Hope EMS 2021- Final Draft .pdf


LincoInville EMS 2021- Final Draft .pd


Camden EMS 2021- Final Draft .pdf


Rockport EMS 2021- Final Draft .pdf

Appendix D - Select Board Information Sessions Slide Program


Version 2.2 Camden-Rockport-Pl

Appendix E - Project Staff Advisors Team

Kevin McGinnis, MPS, Paramedic Chief (Retired)

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 47 years of experience in EMS systems development. Former director of Maine EMS and Maine's E-911 Program, he received the Governor's EMS Award from Governor King in 1997. He authored *"The Rural and Frontier EMS Agenda for the Future"* a milestone book for the federal government and the National Rural Health Association. He coined the term "community paramedicine" a concept now in wide use worldwide. In 2018, Kevin received the *Journal of EMS* "Top Ten Innovator Award". He was named by the Government *Technology/Solutions for State and Local Government* magazine as one of its 2013 "Top 25 Doers, Dreamers & Drivers in Public-Sector Innovation".

He is the past Chairman of the U.S. Department of Homeland Security's SafeCom Program and continues to serve on its Executive Committee. Kevin is Vice-Chair of the Governing Board of the National Public Safety Telecommunications Council and was bestowed its top honor, the Richard DeMello Award, in 2017.

In August, 2015, he was named by the U.S. Secretary of Commerce to a second three-year term on the First Responder Network Authority (FirstNet) Board of Directors and termed out in October, 2018.

Mr. McGinnis has been an ambulance service chief of hospital, private, and volunteer ambulance services in Maine and New York, and has significant paramedic experience with urban, suburban, and rural fire rescue/first responder, and ambulance services. 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 degree from Brown University and a graduate degree from Cornell University, both in hospital and health services administration, and holds or has held a variety of EMS clinical and instructor certifications. He has practiced as an EMT or paramedic throughout most of his career.

Mr. McGinnis has participated as principal consultant, or on federal consulting for state or local EMS system evaluations in Arkansas, Alabama, South Dakota, New York and Montana. As a state (Maine) and regional EMS director, he has evaluated and assisted dozens of EMS operations of every type. He has completed service assessments and strategic planning projects throughout Maine.

Richard Narad, D.P.A., J.D.

Rick Narad is professor of health services administration at California State University, Chico. His research interest is public policy related to the planning, implementation, and management of emergency medical services systems. His publications have included evaluation of ambulance regulatory programs, modeling of changes in the ambulance industry, and a model for comparing public and private services.

Dr. Narad started in EMS administration in 1979. He served as Executive Director of the Merrimack Valley (Massachusetts) EMS Corporation and as EMS Coordinator for Sonoma County (California). He has provided consulting services to state and local governments regarding planning, implementation, and evaluation of EMS systems and has served as an expert witness in cases related to EMS.

He received an A.S. in Fire Science from Santa Rosa Junior College in 1975 and a B.A. in Health Care Management from CSU, Chico in 1979. He received his MPA., with a specialty in health services administration, and his DPA., with a specialty in health policy, from the University of Southern California. He also received his JD, with a focus on health law, from Concord Law School and is a member of the State Bar of California. He is a Fellow of the American College of Healthcare Executives.

Dr. Narad served as president of the Northern California EMS Administrators Association and as chair of the American Society for Testing and Materials' Committee

on EMS. He was treasurer of the California Association of Healthcare Leaders and a member of the National EMS Museum Foundation Board of Trustees. Currently, he serves as a board member and as an operations manager of Safe Space Winter Shelter and is a member of the California Medical Assistance Team.

Michael Senecal, NRP

Mr. Senecal is the director of North Star Emergency Medical Services, serving Franklin County, Maine. He attended the University of Illinois and Frontier Community College. He has been with North Star for eighteen years, helping to forge it from five separate ambulance services previously serving the county. North Star is operated by Franklin Memorial Hospital, a part of the Maine Health System. Mr. Senecal oversees 85 employees and a budget of $4.3 million. He also serves as the hospital's emergency preparedness coordinator.

TOWN OF HOPE

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www.hopemaine.org

Amy Drinkwater, Chair
Wil O'Neal, Director
Maine EMS Board
152 State House Station Augusta,
ME 04333-0152

RE: Town of Rockport – Application for Transporting Ambulance

November 15, 2024

Service Dear Chair Drinkwater and Director O'Neal:

The Town of Hope has been made aware that the Town of Rockport has applied to Maine EMS to become a Transporting Ambulance Service. For decades the Town of Hope has participated with the Towns of Lincolnville, Camden, and Rockport in a regional ambulance service. While we respect the Town of Rockport's ability for self-determination, the choice has potential negative impacts on the current regional EMS and the Town of Hope.

For example, if the contractual amount paid by the Town of Rockport to the current regional EMS provider is apportioned among the remaining communities utilizing the regional service the Town of Hope's share increases by an amount in excess of $92,400. For a community of 1,698 that equates to an annual increase of more than $54 per person or 56%. For any municipal service, a 56% increase in cost without a corresponding increase in the level of service for a user borders on unconscionable. For the Town of Hope, a potential 56% cost increase would likely translate into the community seeking a diminution in the level of service to an affordable level. A lesser level of service at a greater cost serves no one well.

We believe that a regional service strengthens the region. Again, while we do not oppose the Town of Rockport exerting its ability for self-determination, it is important to recognize that this decision has implications, both financially and potentially to service quality, elsewhere.

Sincerely,

Samantha Mank
Town Administrator

CC: Jon Duke, Rockport Town Manager
Audra Caler, Camden Town Manager
David Kinney, Lincolnville Town Administrator
Rick Petrie, NEMHS

TOWN OF LINCOLNVILLE

493 HOPE ROAD
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November 14, 2024

Amy Drinkwater, Chair
Wil O'Neal, Director
Maine EMS Board
152 State House Station
Augusta, ME 04333-0152

RE: Town of Rockport – Application for Transporting Ambulance Service

Dear Chair Drinkwater and Director O'Neal:

The Town of Lincolnville has been made aware that the Town of Rockport has applied to Maine EMS to become a Transporting Ambulance Service. For decades the Town of Rockport has participated with the Town of Lincolnville and other area communities in a regional ambulance service. While we respect the Town of Rockport's ability for self-determination, the choice has potential negative impacts on the current regional EMS and the Town of Lincolnville.

For example, if the contractual amount paid by the Town of Rockport to our the current regional EMS provider is apportioned among the remaining communities utilizing the regional service the Town of Lincolnville's share increases by an amount in excess of $125,000. For a community of 2,312 that equates to an annual increase of more than $54 per person or 78%. For any municipal service, a 78% increase in cost without a corresponding increase in the level of service for a user borders on unconscionable. For the Town of Lincolnville, a potential 78% cost increase would likely translate into the community seeking a diminution in the level of service to an affordable level. A lesser level of service at a greater cost serves no one well.

We believe that a regional service strengthens the region. Again, while we do not oppose the Town of Rockport exerting its ability for self-determination, it is important to recognize that this decision has implications, both financially and potentially to service quality, elsewhere.

Sincerely,

David B. Kinney
Town Administrator

cc: Jonathan Duke, Rockport Town Manager
Audra Caler, Camden Town Manager
Samantha Mank, Hope Town Administrator
Rick Petrie, NEMHS