# Vermont Emergency Medical Services
# Advisory Committee

## Meeting Minutes

**Date**: June 18, 2025
**Location**: Waterbury State Office Complex & Microsoft Teams
**Attendance**: Drew Hazelton, Adam Heuslein, Jim Finger, Leslie Lindquist, Matthew Parrish, William Moran, Bobby Maynard, Joe Aldsworth, Dan Wolfson, Courtney Newman, Chelsea Dubie, Bill Camarda, Connor Dunn, Kate Rothwell, Scott Richardson, Pat Malone, Charles Piso, Samantha Atwood, Jeff Johansen, Jay Symonds, Stephanie Grover, Marc Schauber, Erik Rosenbauer, Bill Camarda, William Fritz, Kathy Jochim, Courtney Newman, Emma Harrigan, Aaron Collette, Jenny Samuelson, Ted Fisher, Brendan Krause, Dave Berman, Ray Walker, Scott Brinkman, Michael Trabell

Meeting called to order 1 PM by Drew Hazelton

**Summary -** The EMSAC meeting highlighted growing alignment between Vermont's EMS system and broader health care reform efforts. EMS leaders voiced practical challenges, especially around funding, protocols, and workforce, while state officials urged agile, participatory innovation. Acceptance of the EMS system assessment marks a turning point, enabling a shift toward concrete planning, legislative engagement, and sustainable EMS integration into Vermont's future healthcare system. The committee will meet next in early July to discuss EMS governance structure.

## Introductions and Organizational Shifts

- Dan Bergman, former FEMA official, is the new Director of the Division of Emergency Preparedness, Response, and Injury Prevention, replacing Will Moran, who has returned to the lead the Office of Emergency Medical Services.
- Extensive participant list included EMS chiefs, state officials, district chairs, and healthcare partners, with in-person and virtual attendance.

## Agency of Human Services (AHS) Perspective

Secretary Jenny Samuelson delivered a strategic address focusing on:

- Vermont's healthcare system is financially unstable; premiums are unaffordable for many.
- The Oliver Wyman report, commissioned by the legislature, highlighted EMS's potential role in systemic transformation:
    - Key areas: emergency and non-emergency transport, shifting care from hospitals to community settings.

    - Specific models: Community EMS, mobile integrated healthcare (MIH), and community paramedicine.
- EMS was encouraged to actively contribute to AHS's short-, mid-, and long-term reform work.
    - Short-term (6 months): Rapid innovations addressing care transition from hospitals.
    - Mid-term: Scaling sustainable models like MIH and alternative transport protocols.
    - Long-term (by 2026): Full integration of EMS in Vermont's healthcare system redesign.

## Key Concerns Raised by EMS Stakeholders

### Systemic Barriers

- Lack of mental health and substance use crisis response infrastructure in rural areas.
- Delayed or inconsistent response times from mobile crisis units.
- Insufficient beds and alternative destinations for mental health patients.
- EMS agencies often lack legal and procedural authority to bypass emergency departments without risk of liability.

### Funding and Reimbursement

- Current funding models are unsustainable, especially for MIH and non-transport interventions.
- EMS leaders emphasized the need for reimbursement reform, particularly from Medicaid, Medicare, and private insurers.
- Bennington Rescue reported their payer mix: 64% Medicare, 23% Medicaid, 7% commercial, 2% self-pay.
- The Green Mountain Care Board (GMCB) may have rate-setting authority for EMS, but that remains unclear.

### Workforce and Infrastructure

- Recruitment and retention challenges, especially for embedded social workers and behavioral health providers.
- Concerns that small and rural EMS agencies may be overburdened by new expectations without added funding or staffing.

Strategic Opportunities and Pilot Programs

- Agencies like Bennington Rescue and Burlington Fire volunteered to pilot MIH and community EMS programs.
- Use cases discussed:
    - Post-overdose follow-ups and buprenorphine induction in the field.
    - CHF/COPD patients receiving home-based follow-up care.
    - Fall prevention home assessments for seniors.
    - Diversion of non-acute mental health calls away from EDs to community-based alternatives.

## Cambridge Consulting Assessment Report

Status and Acceptance

- The final EMS system assessment by Cambridge Consulting is complete.
- Key findings:
    - EMS costs approx. $96 million/year, with a projected $8 million deficit, even with municipal and grant support.
    - Wide disparities in EMS coverage and service levels across Vermont.
    - Persistent workforce shortages, despite state investment in training and certification programs.
    - Significant dispatch inefficiencies, lack of uniform data reporting, and inadequate mutual aid coverage in rural areas.
- Motion by Pat Malone – To accept the final EMS system assessment report by Cambridge Consulting and release it publicly.
    - Seconded by Matt Parrish.
- The committee voted to accept the report with a cover letter acknowledging:
    - Limitations in accuracy, especially service-level data.
    - Ongoing work to verify and refine the data by December 2025 for legislative reporting.
- Vote Result – Motion passed unanimously (no objections).

Data and Transparency

- Discrepancies noted in call volume, financial reporting, and service classifications.
- Decision: Release the report; this is a document that informs the work of the committee.
- Further data validation will be conducted via direct outreach to all ambulance services to ensure accuracy in final legislative reporting.

## Discussion on Future Planning

- Committee members debated:
    - Whether EMS should define MIH applications, or AHS should set statewide priorities and let EMS tailor responses.

    - Need for clear payment models, not just pilot funding or voluntary hospital partnerships.
    - Legislative, rule, and protocol barriers that must be addressed to enable change (e.g., transport rules, EMS scope of practice, billing policies).
- Strong interest in a phased rollout of reform, starting with early adopters and supported by payment model testing through AHS and GMCB collaboration.

## EMS Governance

- A presentation was made on EMS governance, defining it as:
    - EMS system governance refers to the framework of rules, regulations, and oversight that guide the organization, management, and delivery of EMS.
    - EMS system governance is a multi-layered structure that aims to ensure that emergency medical services are delivered safely, effectively, and efficiently, while also being accountable to the public and the communities they serve.
- Components of EMS governance includes legal authorities, organizational structure, oversight, resource management, human resources and training, coordinated response and specialized transportation, communications and information management, medical direction, collaboration and coordination, and data collection and evaluation.
- In the future the committee will discuss the framework of the EMS governance system, and will decide the level(s) each component will be nested in. These include agency, region, state, advisory committee, and other.
- Drew Hazelton facilitated a survey of 37 questions posed to the committee members covering a range of topics to gain insight into what components belong where within the governance structure.
- The committee endorse the proposal to have Katherine Sims facilitate the next committee meeting on July 9th, 2025, which will focus on EMS system governance.

## Next Steps

- The EMSAC will:
    - Finalize and distribute the Cambridge report with disclaimers.
    - Begin validating service-level data with all EMS agencies starting July.
    - Develop priority use cases for MIH to propose to AHS and GMCB.
    - Continue engaging in regional healthcare transformation meetings.
- The next EMSAC meeting will be held at the Waterbury State Office Complex on Wednesday, June 9th, from 10 AM to 4:30 PM, at the Cherry A conference room.

The meeting was adjured at 3:30 PM