Sustaining Rural Emergency Medical Services

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The views and opinions expressed in this presentation are those of the individual presenter(s) and should not be attributed to MDH, Sanford Health, EMSRB, MAA, or other stakeholders mentioned throughout the presentation.
Minnesota Rural EMS Assessment - 2016

2002 “A Quiet Crisis: Minnesota’s Rural Ambulance Services at Risk”

2015 “Rural EMS Sustainability Summit Report

2015 “Rural Ambulance Service Attributes Survey Tool


Minnesota Rural EMS Assessment - 2016

Funded in part through the Medicare Rural Hospital Flexibility Program
Partnership with MDH / EMSRB / MAA’s Rural EMS Sustainability Committee
Pilot-tested in Southeast and Greater Northwest EMS Regions
May 2016 survey sent to 230 rural EMS managers - anonymous replies
81% response rate (186)
Key Findings: Characteristics of Rural Agencies

Most rural EMS agencies provide basic life support services to relatively small populations spread across large geographic areas. Along with low daily call volumes, these realities exacerbate the inability to create sustainable business and staffing models.

- The median call volume is nearly one call per day
- Over half of agencies cover > 200 square miles, 37% > 300 square miles
- Over half of agencies serve populations < 5,000
Key Findings: Workforce and Staffing

The active roster decreased for half of the agencies from the previous year.

About 60 percent of agencies have inadequate staff to cover their call schedule without undue burden to the agency.

59 percent of agencies do not have their shifts 100 percent covered at least 24 hours in advance.
Key Findings: Workforce and Staffing

Recruitment and retention is a significant challenge even though:

- Emergency Medical Responders are widely used to actively staff agencies
- Most agencies cover full cost of the continuing education course for staff
- Most eligible recipients take advantage of state EMS training reimbursement
Obstacles to recruiting EMS staff

- Time Commitment is too Great: 67%
- Lack of Availability: 62%
- Training Requirements Time Consuming: 58%
- Lack of Trained Candidates: 50%
- Inadequate Pay or Benefits: 40%
- Childcare Responsibilities: 38%
- Training Requirements Far Away: 23%
- Too Few Runs or Transports: 14%
- Too Many Runs or Transports: 9%
- Other: 5%
Obstacles to retaining staff

- Excessive Time Commitment: 72.0%
- Age: Older Crew Members Retiring: 60.2%
- Inadequate Pay or Benefits: 39.3%
- Employer Does Not Allow Staff to Leave Work: 37.1%
- Certification is Too Difficult to Maintain: 25.8%
- Limited Advancement Opportunities: 22.6%
- Lack of Recognition: 14.0%
- Too Many Runs or Transports: 10.8%
- Community is Too Isolated: 10.2%
- Too Few Runs or Transports: 9.7%
- Dissatisfaction with EMS Manager: 5.4%
- Dissatisfaction with Job Duties: 3.2%
- Dissatisfaction with EMS Manager: 1.6%
- Other: 9.7%
Key Findings: Leadership & Financial Management

- Recruitment: 69%
- Staffing the Schedule: 51%
- Retention: 43%
- Continuing Education Requirements: 32%
- Managing Staff: 31%
- Policy Development and Enforcement: 25%
- Staff Certification: 20%
- Budget Development: 17%
- Billing and Reimbursement: 15%
- Maintaining Equipment: 11%
- Medical Direction: 10%
- None: 9%
- Licensing Requirements for the Ambulance: 5%
Key Findings: Leadership & Financial Management

86 percent of services did not have high turnover of their managers

81 percent of rural EMS managers have a role in developing their annual budgets

81 percent use other resources to bill, with billing agencies as the most common at 52 percent
Key Findings: Medical Direction

88 percent report that they do not have difficulty recruiting or retaining a medical director.

26 percent of rural EMS agencies participate in a medical direction consortium.
Key Findings: Community Relations

94 percent of rural EMS agencies provide additional non-response services to their communities.

More than 62 percent of agencies believe that community support for EMS is similar to other public services.

82 percent do not have a community advisory board.
- Sporting Events: 74%
- CPR/AED Classes: 66%
- Health Fair: 57%
- First Aid Training: 53%
- EMS Training: 51%
- Blood Pressure Monitoring: 29%
- Adopt a Highway: 8%
- Other: 8%
- None: 7%
Summary

With some small exceptions, rural EMS has remained the same in Minnesota from 2002-2016. The same business problems of economics and structure exist. For example:

Low transport volumes | Low and sparse populations served | Population changes in seasonal density and distribution | Large geographical primary service areas | Availability of a sustainable workforce, including dependence on volunteers | Need for fully engaged medical directors | Need for non-transport revenue
Summary

Need for further and deeper understanding of what this means

EMS is a vital link in the healthcare continuum

Without EMS, patients in need of time critical care for conditions such trauma, stroke, allergic reactions and cardiac emergencies will suffer unnecessary death and disability.

EMS must survive for Minnesota’s rural citizens and visitors to have the best chance to survive these and other emergencies
Rural EMS Sustainability

Vision: To develop and promote comprehensive solutions that enable rural ambulance services to operate sustainably.

Sustainability is the endurance of systems and processes. - Wikipedia

Sustainability is: Supporting a system that meets the needs of our communities.

Sustainability is not: Supporting a system the meets the wants of everyone.
Leadership: Leaders have a lack of direction. How do they know where to go for the future?

Workforce: There is a balance between quality employees and an employee who shows up, in rural areas people have other jobs, responsibilities.

Funding: Many have donation based systems, i.e. fundraisers. Very few are completely self-sustaining.

Community Awareness: The average person makes the assumption that fire and EMS are interchangeable. Hospital staff don’t alway know how EMS works.

Education/Training: Education is becoming too demanding, takes too much time and is expensive.

Medical Direction: Access to the medical director when you need them is important.
MAA Rural EMS Sustainability Committee

Includes Representation from:

• MAA
• EMSRB
• MDH ORHPC
• Regional EMS programs
• Many other stakeholders
Goals of the Committee with the Future in Mind

• Develop a fundamental leadership program for EMS leaders.

• Expand the Statewide Mentor Program.

• Create resources to educate stakeholders on EMS workforce sustainability.

• Define “community” and “awareness” to understand how we can benefit.

• Engage the MAA education committee.

• Develop a baseline understanding of funding models.

• Promote the delivery of successful medical direction.
“The greatest need is for leadership and action” (Becknell, 2011)
Leadership

- Developing the capacity of local ambulance service leaders.
- The best-run rural ambulance services have stable, prepared, respected, and proactive leadership.
- Investing in leadership development helps overcome local unique challenges.
- MDH grant for leadership course
- Mentor (pilot) program
Create Resources to Educate Stakeholders on EMS Sustainability

- Many resources available
  - [https://www.health.nd.gov/media/1320/ruralems-leadersurvivalguide.pdf](https://www.health.nd.gov/media/1320/ruralems-leadersurvivalguide.pdf)

- Studies show our current model is not sustainable.

- Volunteerism is not sustainable

- Based on the MDH survey results we know our current staffing model is failing
Define “community” and “awareness” to understand how we can benefit.
Engage the MAA education committee.

- The MAA Education committee was tasked with creating recommendations to a Rural EMS Sustainability Committee goal.

- The goal we were given is to define barriers to certification/education/recertification related to rural EMS sustainability.

- The group drafted a document outlining issues and solutions.
Develop a baseline understanding of funding models.

- Find alternative funding
- Find methods we can help (us and) others understand what it takes to fund an EMS system.
- Develop funding fact sheets, which has been developed on other states.
- Outline what it takes to run an EMS system
Promote the delivery of successful medical direction.

- Our goal is that all ambulance services will have engaged, successful medical direction.
- Develop a higher degree of collaboration with available resources.
- Provide services resources to effectively engage medical directors.
- 88 percent report that they do not have difficulty recruiting or retaining a medical director.
- 26 percent of rural EMS agencies participate in a medical direction consortium.
Summary

• Develop Leaders
• Engage Stakeholders
• Find Sustainable Solutions!
• Stimulate Change!
History of EMS

EMS 1.0 – Fast response and transportation

EMS 2.0 – Fast response of quality care and transportation

*Accidental Death and Disability: The Neglected Disease of Modern Society – NHTSA 1966*

*EMS Systems Act of 1973*

Suppliers of transportation

Rewards EMS for driving up healthcare system costs by using the highest-cost transportation resource (an ambulance) to transport patients to the highest-cost healthcare provider (an emergency department) without any real proof of value for most patients. *EMS 3.0 The Future of Service Delivery, Reimbursement, Education, Dispatch, Medical Direction, Technology and Regulation. - NAEMT*
Future of EMS

EMS 3.0

• Emergency Medical Dispatch
• Emergent response and assessment
• Clinical intervention and transportation for time-sensitive emergencies
• Navigating the health-care system for most appropriate destination
• Chronic disease management and support
• Post-discharge follow up, preventive care
• Nurse advice
Final Thoughts

- Many rural EMS system models are not sustainable.
- Is the EMS system in your community sustainable?
- What are the struggles locally?
Final Thoughts

• Is EMS in your region sustainable?

• What is your role in EMS sustainability?
Conclusion
References


Thank You!

Open Discussion