

Small Fish in a Big Pond: EMS Issues in Greater Minnesota

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Why should rural communities be concerned about their local ambulance service? Because if they aren't, they might find themselves without one located in their community, as has happened in the Minnesota communities of Belview (2002), Wykoff (2003), Osakis (2004) and Kenyon (2006).

Since 9/11 there has been immense federal, state, regional and local support provided to public safety agencies to combat potential terrorism. Public health and health care providers have also received extra public funding aimed at the potential threats of bird flu and bioterrorism. But as the only professional group currently operating in all three sectors, ambulance services remain a step-child of each.

"We're first responders!" say police and fire agencies. "We're first receivers!" tout hospitals. "Our surveillance and prevention can stop the spread and save the masses!" cries the public health system. Yet there is another piece to this puzzle. When not enough of the public has been surveilled to ring the alarm yet, but they've been triaged by the first responders, somebody must take them to the first receivers.

Most of Minnesota's ambulance services are located in rural areas (231 vs. 41 in urban areas), even though the majority of ambulance volume is in metropolitan areas. Only 25 of 272 ambulance services operated in areas with more than 40,000 residents in 2002, with another 26 in areas of 20,000 to 40,000. The typical rural ambulance service has 26 personnel, two ambulances, and transports 480 patients per year to hospitals two to 70 miles away. On a per-capita basis, both urban and rural Minnesota ambulance services transport about five people per 100 residents¹.

For every paid ambulance worker in Minnesota, there are 1.4 volunteers. Of 4,533 rural ambulance personnel in Minnesota in 2002, 3,481 were volunteers. To be a volunteer, each person must complete 110 hours or more of initial medical training, plus 24 hours or more of training every two years. The average ambulance attendant is

20 to 40 years old and has been in the business six years or more. Daytime hours, weekends and holidays are the most problematic shifts to fill, and about 900 ambulance personnel, half from rural areas, leave an ambulance service each year. At any given time, 74% of Minnesota’s ambulance services are trying to add staff.²

Recent EMS Topics

The ambulance industry has been through considerable change over the last decade, and the industry’s issues are magnified in rural areas, where demands are high but resources scarce.

The National Rural Health Association (NRHA) recently described rural EMS as “under-developed,” “under-technologized,” and “under supported.” In its 2005 briefing,³ NRHA listed (in no particular order) recruitment and retention, inadequate reimbursement, training, transport distances and medical direction as the five major issues facing the industry. At a summit in October 2006, nearly 50 EMS leaders in Minnesota identified the top five issues for the industry, in order, as regional program support, workforce and staffing, funding, quality improvement and leadership.

Each of these two independent events identified an identical set of EMS issues, as noted in the chart below.

EMS Issue	MN EMS Summit	NRHA Workforce Paper
Care Barriers	Regional Program Support	Transport Distances
Workforce	Workforce & Staffing	Recruitment & Retention
Finances	Funding	Inadequate Reimbursement
Performance Improvement	Quality Improvement	Medical Direction
Management	Leadership	Training

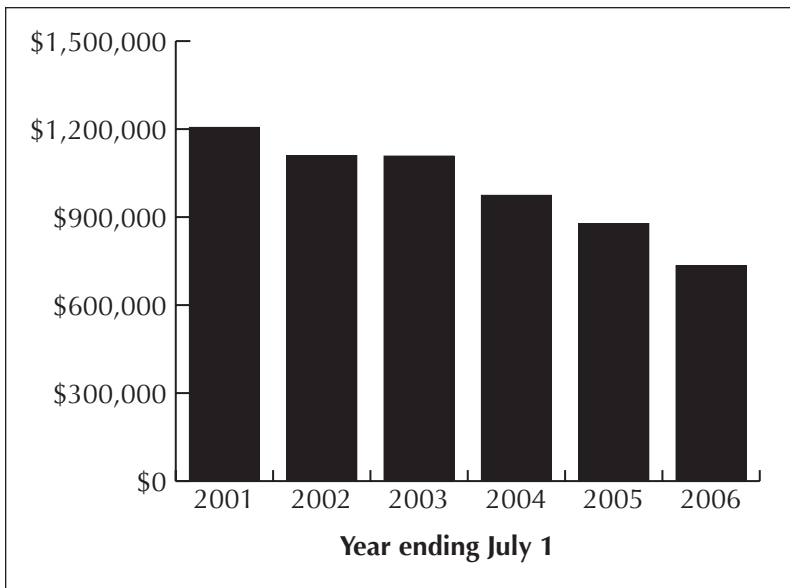
Care Barriers. Minnesota’s EMS system is unique. The state essentially grants an exclusive franchise to a provider for a given territory. In exchange, the ambulance service must answer all requests for service, regardless of ability to pay, 24 hours a day. The system consists of local providers, eight regional EMS programs and a state board financed by the state’s general fund. Eight regional EMS programs are financed primarily through a combination of state aid and seat belt violation fines. Local providers are funded primarily through user fees, which in some cases are supplemented by local taxes.

Minnesota’s eight regional EMS programs operate either as non-profit companies or joint powers boards. Their state aid grant funding is tied to overall state objectives. Their share of seat belt fines, however, is controlled by the board of directors for the regional entity. This mix of funding addresses issues of statewide significance while at the same time meeting local needs.

In recent years the funds used by regional EMS programs to address local needs — seat belt fines — have been decreasing. The reasons for this are unclear: there has not been a substantial rise in seat belt usage. Some believe law enforcement officers are writing fewer tickets, that fines are not being prosecuted, or that the seat belt fine is plea-bargained away at the judicial level. Also, while the seat belt fine itself is modest (\$25), surcharges that can be added to the fine to fund such things as judicial libraries and local courts can push the final cost to an unacceptable level, in many cases exceeding \$75, potentially creating a situation where officers are reluctant to write the ticket, prosecutors are reluctant to prosecute it, and it is easier for the courts to dismiss the seatbelt violation than the actual reason the person was stopped in the first place (seat belt violations are a secondary offense in Minnesota).

Workforce. The government tells us volunteerism is on the rise in America, which may be true in some sectors of society, but not in

Figure 1: Seat belt funds distributed to Minnesota regional EMS programs.



EMS. Staffing an ambulance is harder to do than staffing a fire truck. The reason is simple: the ambulance crew is much busier. When a community calls on its volunteer fire crew once every other month, the burden of volunteering is minimal. When a volunteer must commit to 12-hour shifts three or more days a week and is called into service one or more times each shift, the burden of volunteering is significantly increased.

Thus, recruitment and retention of volunteer ambulance personnel becomes a fine art. Rural volunteer ambulance services across Minnesota have been experiencing a crisis in recruiting and maintaining staff to provide pre-hospital emergency medical services. The Office of Rural Health and Primary Care⁴ highlighted this crisis in a 2002 study of volunteer ambulance services. The study identified several areas for consideration, including “perceptions about the nature of the work, time and training demands, compensation, and changing demographics.” The study also reported that of all rural ambulance personnel, nearly half (45%), are age 40 or older.

The combination of these factors jeopardizes the very existence of rural ambulance services and their ability to respond to the critically ill and injured. The Emergency Medical Services Regulatory Board (EMSRB) is the state agency charged with regulating access and care provided by pre-hospital care providers. Ensuring the recruitment and retention of staff is critical to the shared mission of the state and regional boards in protecting the public.

The EMSRB estimates there are more than 400,000 requests every year in the state for an ambulance. Unfortunately, some who call 911 face extra wait time for the next closest ambulance to come because their local ambulance service has closed. This can result in an extra 30- or 40-minute wait before the ambulance from the next town can arrive to provide care. This example is becoming more of a reality than fiction as the workforce of rural ambulance services ages and ways to motivate the current generation to volunteer are not completely understood.

Little research has been conducted on recruitment and retention issues for rural volunteer ambulance services. Many journals document the crisis of recruiting and retaining personnel, but few suggest solutions. Literature from other healthcare industries, specifically nursing, might provide concepts that could easily be adapted and applied to rural ambulance services.

Current and future leaders of ambulance services should be interested in this topic as they strive to understand what motivates people today and what may motivate people in the future to become

part of their organizations and to understand techniques that will maintain the workforce. Without this knowledge, recruitment of personnel will be extremely difficult, and those who are recruited might not be the type of personnel they desire. The problem is compounded when they have recruited the right personnel and invested countless dollars in training them only to lose them. With these losses the vicious circle begins again.

Finances. The average ambulance service in Minnesota has seen a 58% reduction in Medicare payments since 2002.⁵ In the Balanced Budget Act of 1997, Congress mandated that Medicare put ambulance services on a fee schedule. Prior to 2002 when the fee schedule was adopted, Minnesota's ambulance services received higher payments than those in other states. When the fee schedule was fully implemented Jan. 1, 2006, it nationalized the payments, hitting Minnesota providers particularly hard.

Many ambulance services have made adjustments in their operations and pricing to accommodate these lower payments, but there is still work to be done. There are best practices that can be put into place to help mitigate loss of fees, some examples of which can be found in the *Recommendations* section.

Performance Improvement. Quality and performance are the current buzz words in healthcare. "Pay for Performance," still in the experimental stage, may become the payment methodology for health care in the future.

Much of the federal activity in the health arena surrounds performance and quality improvements, benchmarking and indicator development. Some activity also exists within EMS in these arenas through development of the National EMS Information System (NEMSIS), the Open Source EMS Initiative's Performance Indicator Development Project, and the National EMS Performance Measures Project. However, EMS is behind the curve in relationship to other sectors of the healthcare community.

EMS can lead other sectors of the healthcare community in implementation of data systems because EMS already has both a national common data dictionary that has standardized the data elements and a uniform transaction standard for passing data from the provider to the state and to the federal government. Now, instead of data vendors keeping data systems proprietary, they are all forced to compete on cost and quality. Minnesota is a leader in the national system, too, and should be proud that it is one of the first five states to begin reporting data into the national EMS data bank, thanks to

the efforts of the EMSRB and all the ambulance services.

After watching performance measures fail rural hospitals miserably, the North Central EMS Institute, based in St. Cloud, led a national consensus process in June 2005 to develop measures applicable to every ambulance service in the country. While outcome measure reporting is not yet mandated for ambulance services, many believe it soon may be and that payments will be based upon it, and now, thanks to Minnesota efforts, workable measures identified.

Having access to a physician for medical direction is still an issue for some rural ambulance services. Here also innovative models of regionalized medical direction in our state have become national models. For nearly 20 years ambulance services in southeast Minnesota have been able to receive medical direction through a consortium operated by their regional EMS program. This has provided services with high quality medical directors who are interested in EMS and are willing to help them make a difference. A similar model is available in the south central region.

Minnesota's EMS data collection system, operated by the EMSRB, is also able to produce some quality reporting back to ambulance services. Many services have used the system to work with local elected officials and others to secure funding.

Management. While some rural ambulance services still operate with governing boards consisting solely of the ambulance staff, that model is no longer feasible. All of the issues previously raised require that today's ambulance services be managed by accountable boards.

While recruitment and retention issues in EMS are concerns, businesses cannot be operated by untrained management and remain sustainable. In the case of ambulance services that are "owned" by city councils or counties, elected officials have fiduciary responsibility to the corporation in addition to their responsibilities to assure service to the citizens. It is not enough for the local ambulance service simply to report once or twice a year to the city council; the council itself must assure the viability of the entity throughout the year.

Recommendations

There are several steps individuals and communities can take to help their local EMS system address these major issues.

- *The Minnesota legislature should not allow additional surcharges to be added to the seat belt fine.* Since the seat belt ticket revenue provided to Minnesota's regional EMS programs

is decreasing and it is not a result of increased seat belt usage, the parties that receive the surcharges that are added to the fine may not need them. If they did need this revenue, tickets would be written, prosecuted and upheld. The results of the tickets not being written, prosecuted and upheld are two-fold: the public is left with the message that seat belts aren't important, and the funding that is critical for local EMS needs vanishes.

- ***Dedicate strategic resources to recruitment and retention.***

Many organizations have made significant improvements in recruitment and retention by dedicating strategic resources toward the issue. The legislature should provide funds to the EMSRB to add one staff member dedicated to developing and implementing recruitment activities for rural ambulance services. These activities could include developing a pilot rural ambulance recruitment program that includes templates, promotional materials, and training. A statewide recruitment program would allow rural ambulance services to benefit from the work that has already been completed while still tailoring the program to individual needs.

A statewide recruitment website should be developed and used to link potential volunteers with ambulance services in their area. The site could provide information to interested individuals about EMS as well as expectations and requirements for being an EMT on a rural ambulance service. With a relatively small appropriation, significant improvements in rural ambulance recruitment are possible.

- ***Target the right people.*** Many rural ambulance services already conduct recruitment activities, but their recruitment programs may not be targeting pools of people with the most potential or considering the motivators and barriers for volunteerism of the current generation. Ambulance services should integrate recruitment into their annual planning, with involvement of their governing board. This strategic focus will enable each service to consider recruitment activities at the same level of importance as other strategic items, such as new facilities or vehicles. A cross-functional team should be established to develop and implement recruitment activities. This team could be made up of individuals from the local ambulance service, such as new and experienced EMTs, but also include community members such as church and business leaders and local elected officials. The mix would allow for creative ideas as well as build support throughout the community for the needs of the local ambulance service.

- **Grassroots recruiting.** Ambulance services should have grassroots recruitment programs that encourage staff members to recruit new personnel themselves. A one-on-one connection like this could allow for mentoring of the new individual.

- **Accountable boards.** Ambulance services should have fully functional and accountable boards made up of a variety of talents from within the community. CPAs, elected officials, bankers, leaders of non-profit organizations and others should be represented. Crew members and clients (hospitals, nursing homes, and the general public) should serve as an advisory committee for the board. These boards should complete a strategic planning process that includes examining ways to partner with adjoining services to reduce costs, specifically in the areas of management/oversight and training. While two services in neighboring communities may not be able to support full-time managers individually, they may be able to afford one jointly. Communities that are close to one another should consider combining their ambulance services into one functional unit to achieve other efficiencies.

- **Use professional billing services.** Today's ambulance biller must stay abreast of complex and changing regulations to avoid inaccurate or incorrect billing. At the same time, professional ambulance billing companies have proven more successful at collecting delinquent accounts. Some municipal ambulance services have reported collections increasing by up to 50% by using professional billings services. As no credentialing body for ambulance billing companies exists, the best choice is to select one that is a member of the Minnesota Ambulance Association and the American Ambulance Association. Members of these associations receive regular updates on billing changes.

- **Seek non-traditional volunteers.** Ambulance services worry about recruiting volunteer personnel, but they might also overlook the obvious. It may be possible to recruit a volunteer accountant into the organization or a grant writer for help with grant applications. It might be possible to recruit a stay-at-home parent who could be immediately available to care for children so that another parent could serve as an EMT.

- **Use buying groups.** Members of the Minnesota Ambulance Association have access to national pricing through the North Central EMS Cooperative (NCEMSC). Since NCEMSC has nearly

1,000 members in 24 states, all buying products under the same contracts, substantial savings can be achieved by participating in this program. Minnesota law carves out a special exemption from the state's bidding law for municipal ambulance services to allow them to participate in NCEMSC's programs.

- **Apply for grants.** Many Minnesota ambulance services are eligible for federal grant programs but do not apply because they don't know they are eligible. For example, there is a section of the Assistance to Firefighters grant program that makes non-profit, non-hospital, non-fire ambulance services eligible for portions of that program's funds. Ambulance services that are fire-based are eligible for all of that program's funds.

- **Businesses can contribute.** Little things can make a difference. Ambulance personnel have a considerable amount of required ongoing training. Local pizza parlors could donate pizzas and pop for training night. The local auto dealer could contribute routine vehicle maintenance and assure the ambulance service is accessing available discount programs when purchasing replacement ambulances.

- **Support and use MnStar.** The EMSRB's data collection system holds a wealth of data, information that can be used to report quality measures, make staffing decisions, justify rates, apply for grants and seek financial subsidies. If all goes well at the federal level, MnStar can also provide the data needed to report quality measures under Pay for Performance.

Ambulance services are critical to rural communities where other health care providers are scarce and far between. But rural ambulance services also have a number of inherent issues to address. Some of the keys to maintaining vibrant rural ambulance services are an adequate state support system, excellent board members, adequately trained management, and experienced crew members. But above all, the key to success is a caring community.

Endnotes

¹ Minnesota Department of Health (2002, December). *A Quiet Crisis: Minnesota's Rural Ambulance Services at Risk*. Retrieved December 7, 2006 from Minnesota Department of Health: <http://www.health.state.mn.us/divs/chs/rhpc/PDFdocs/ambulancerpt.pdf>.

² Ibid.

³ National Rural Health Association (2005, November). *Recruitment and Retention of a Quality Workforce in Rural Areas: Number 13 – Emergency Medical Services*. Retrieved November 29, 2006 from National Rural Health Association: <http://www.nrharural.org/advocacy/sub/issuepapers/Workforce12EMS.pdf>.

⁴ Minnesota Department of Health (2002, December). *A Quiet Crisis: Minnesota's Rural Ambulance Services at Risk*. Retrieved December 7, 2006 from Minnesota Department of Health: <http://www.health.state.mn.us/divs/chs/rhpc/PDFdocs/ambulancerpt.pdf>.

⁵ Personal communication: Minnesota Ambulance Association Billing and Financial Data Committee.