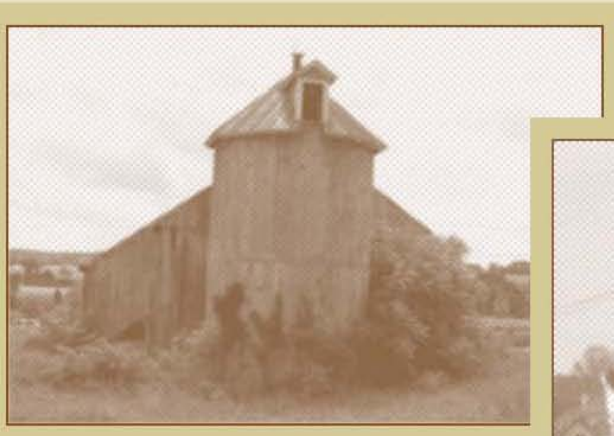
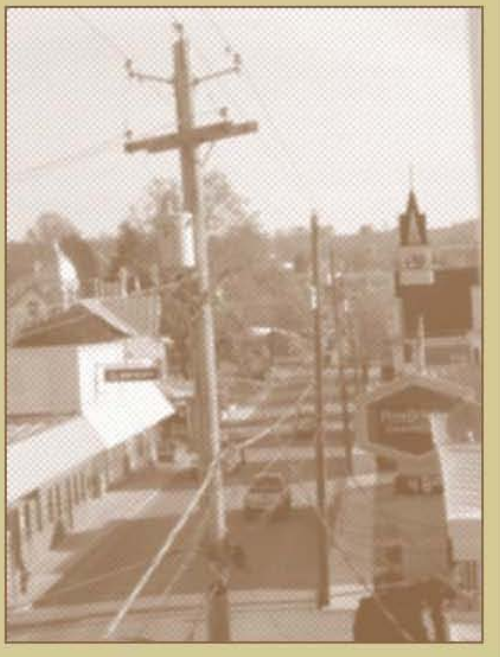
RURAL & FRONTIER EMS TOWN HALL MEETING SUMMARY





U.S. Department of Health and Human Services
Health Resources and Services Administration (HRSA)
Office of Rural Health Policy (ORHP)

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Contents

Foreword

Rural health care is often under-represented in discussions and debates concerning health care delivery. This is particularly true of rural Emergency Medical Services (EMS). In an environment that relies largely on a volunteer workforce, the ability for EMS agency personnel and individual Emergency Medical Technicians (EMTs) to have their voices heard at policy and decision making levels is challenging. The Institute of Medicine recently noted in their *EMS: At the Crossroads* (2006) report "EMS, for example, is unlike any other field of medicine–over one-third of its professional workforce consists of volunteers." (p. xiii)

HRSA's Office of Rural Health Policy (ORHP) has, since its inception, been concerned about ensuring that rural issues are well represented at a Federal policy level. HRSA's Rural EMS and Trauma Technical Assistance Center (REMSTTAC) was charged with the task of helping to ensure that there was a conduit for issues and concerns to be channeled up from the rural EMS community to ORHP. REMSTTAC has assumed that responsibility and conducted a series of town hall meetings in three rural regions of the country. This report describes those meetings and the challenges and concerns that EMS systems in rural America are facing at the grass roots level.

Clearly the findings contained in this report cannot be generalized to "all" rural EMS systems. However, the fact that the findings are consistent with other recent documents such as the *Rural and Frontier EMS Agenda for the Future* and the Institute of Medicine's *EMS: At the Crossroads* report indicates that there are some common challenges that emerge wherever ambulance wheels roll down rural roads. HRSA, ORHP, REMSTTAC and others will have to work together as they attempt to address the issues identified in this report.

We acknowledge those who took the time to participate in one of the town hall meetings. Likewise we appreciate all rural residents who set aside what they are doing when the pager tones to respond to their neighbor's emergency medical needs.

Marcia K. Brand, Ph.D.
Associate Administrator for Rural Health, HRSA

Nels D. Sanddal, Director
Rural EMS and Trauma Technical Assistance Center

INTRODUCTION

Emergency Medical Services (EMS) struggle to meet the needs and demands of citizens in communities across the nation. For rural or frontier communities it is becoming even more challenging to meet the community's needs for prehospital emergency care.

EMS Systems face numerous challenges. First, and foremost, EMS has no clear home as part of the health care system. Although EMS is often the first to treat patients who are injured or become ill, EMS' place within the health care system has yet to be clearly defined.

During a time when much of the country is preparing for large-scale emergency events, rural and frontier America is often faced with trying to find enough volunteers to answer routine calls for a single sick or injured patient. Rural EMS confronts challenges that are much different than those of its urban neighbors. Rural problems often involve a lack of resources, difficulty in recruitment and retention of prehospital providers, and a lack of medical oversight.

With the creation of the Rural EMS and Trauma Technical Assistance Center (REMSTTAC), funded by the Health and Human Resources Services Administration (HRSA), Office of Rural Health Policy (ORHP), it was essential to inform a broad constituency about REMSTTAC and its purpose. It was equally important to solicit first-hand information concerning the challenges facing rural EMS providers – from their perspective. The purpose of the Town Hall Meetings was three fold: 1) to provide exposure for REMSTTAC, 2) to be a conduit to and from ORHP to those working in the field of rural and frontier EMS, and 3) to discuss key features of the *Rural and Frontier EMS Agenda for the Future*. Additionally, town hall meetings provided a forum for information gathering for the EMS workforce study being conducted by National Highway Transportation Safety Administration (NHTSA) with a wide variety of partners. While most of these partners do not specifically represent rural issues, strong rural representation is involved in the NHTSA process, including REMSTTAC, ORHP, the National Association of State EMS Offices (NASEMSO), the National Rural Health Association (NRHA) and others.

METHODS

The concept of regional information gathering workshops was identified in the original solicitation by ORHP to create a Rural EMS & Trauma Technical Assistance Center, and these workshops were included in the Earthtalk Studios / Critical Illness & Trauma Foundation (CIT) response to the solicitation. (Earthtalk and CIT, under contract with ORHP, are responsible for the operation of REMSTTAC). The need to gain first-hand knowledge of the needs of rural EMS providers was confirmed as a priority activity following the award of the contract, during the first meeting of a REMSTTAC Stakeholder Group created to oversee the project, and was supported by the ORHP project officer. The initial meeting was held in conjunction with the annual grantee meeting for the Rural Automated External Defibrillator (RAED) program; thereafter, adjustments were made to the venue selection process, and the Town Hall meetings became freestanding.

As with each of the tasks associated with the REMSTTAC contract, a task group of REMSTTAC staff and individuals from the Stakeholder Group was assigned to carry out the project. Teri L. Sanddal, Associate Director of REMSTTAC, was the lead staff person; she was supported by Heather A. Soucy, Program Support Specialist for REMSTTAC. Stakeholders on the task group included Patrick Malone, Dan Summers, Marilyn Jarvis, and Evan Mayfield.

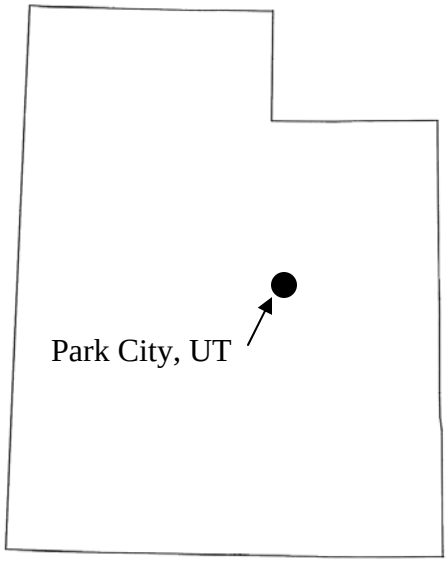
The task group, in consultation with the broader group of Stakeholders, determined the three general locations for the meetings. A preliminary timeline and meeting agenda was agreed upon and created through a consensus process. The task group assigned a local coordinator to assist with the Town Hall Meetings. This task was assigned to Patrick Malone and Dan Summers for New England and Appalachia, respectively. Feedback on the events was solicited through formal written evaluation questionnaires. The questionnaires were structured on a modified Likert scale with a semantic differential rating system. Evaluation questionnaires were distributed and collected on-site.

The agenda for each of the meetings included four general sessions:

1. Who is REMSTTAC, and what does REMSTTAC do?
2. Overview of the *Rural and Frontier EMS Agenda for the Future*
3. Assessment of workforce need (not included in Park City, UT)
4. Discussion of current challenges to Rural EMS including perceived solutions to those challenges.

RESULTS

Park City, Utah, Town Hall Meeting



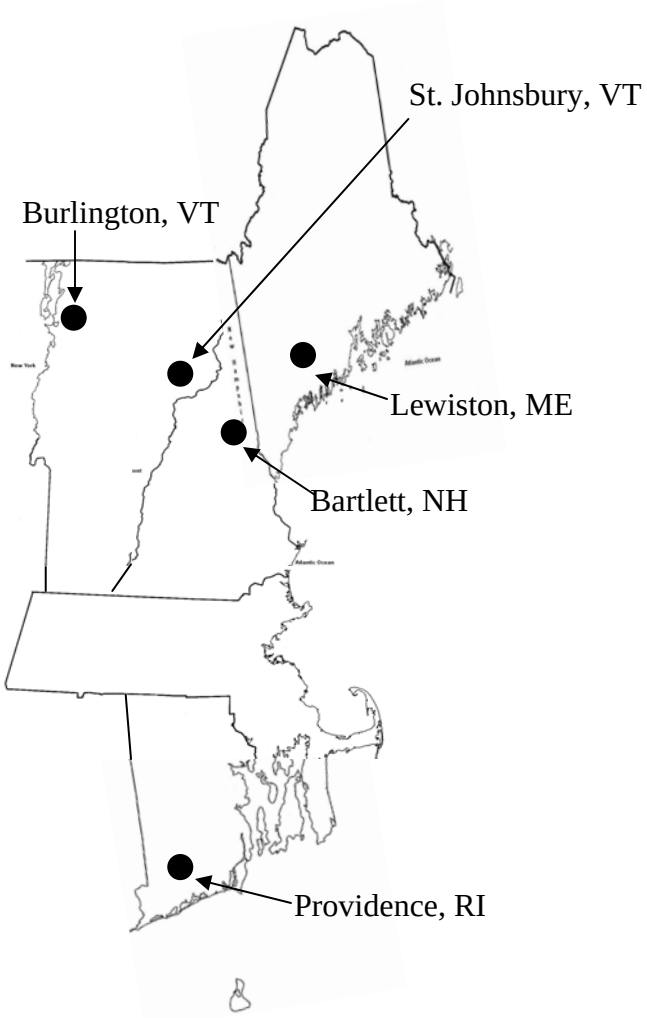
The first of the town hall meetings was hosted in Park City, Utah, in conjunction with HRSA's annual Rural Automated External Defibrillators (RAED) Grantee's meeting on October 4, 2004. The 4-hour meeting began with a series of key presentations: 1) a REMSTTAC overview, 2) Rural EMS Performance Improvement Efforts, 3) Challenges to Rural Trauma Care, and an overview of the *Rural and Frontier Agenda for the Future*. Following these presentations, an open forum and discussion was conducted. Because the meeting was held jointly with the RAED conference, much of the discussion was more focused on matters pertaining to the RAED grant support and technical assistance.

The most important aspect of these discussions was the clear identification of the need for standardized EMS data collection. A consensus was reached among the participants pertaining to the need to use a standardized data set. This led to a discussion concerning the National Emergency Medical Services Information System (NEMSIS) for such evaluation efforts. REMSTTAC staff, and others, suggested to the audience that using NEMSIS would clarify the standard definitions and help improve reporting quality across all grantees. Discussions focused on how REMSTTAC could be more supportive of the RAED grantees, particularly in the area of data collection. Other discussion points centered around how REMSTTAC could help promote and communicate with rural and frontier EMS systems through its Web site, hosting a library of literature that would have information about such topics as: funded vs. not funded trauma and EMS systems, how EMS systems collaborate to make rural EMS work successfully, as well as hosting and distributing the *Rural and Frontier EMS Agenda for the Future*, HRSA *Model Trauma Care Plan,* and other key EMS/trauma documents.

Forty-five individuals attended this inaugural Town Hall meeting, representing 37 States and one territory. All participants were asked to fill out an evaluation of the meeting. Using a modified Likert scale with 1 being poor or not meeting expectations to 5 being excellent, the mean score for meeting the audience's personal objectives was 3.80; presenters scores ranged from 3.2 to 3.8, the overall meeting score was 3.95.

At the conclusion of the meeting in Park City, REMSTTAC staff and the ORHP Project Officer realized that, although the meeting in Park City was a success, REMSTTAC was still not reaching the audience that the Town Hall Meetings were designed to reach - that being "frontline" EMS providers and rural health care professionals. In order to reach this audience, REMSTTAC conducted and held the subsequent meetings in multiple locations within an area and spoke directly to those working in the field. It also was apparent from the Park City meeting that more time was needed for group discussion and identification of pressing topics. Subsequent meetings were adjusted to allow this additional time.

New England Area Town Hall Meetings



The second sets of Town Hall Meetings were hosted in the New England area and were held between October 16 and October 19, 2005. Meetings took place in Lewiston, Maine; Burlington and St. Johnsbury, Vermont; Bartlett, New Hampshire; and Newport, Rhode Island. The final meeting in Newport involved a presentation of findings to the New England EMS Council, which represents EMS agency personnel from six States.

REMSTTAC's local coordinator was Patrick Malone, who represented the New England EMS Council and the Rural EMS Initiative of the University of Vermont, Burlington. Mr. Malone also currently serves on REMSTTAC's Stakeholder group. The Town Hall meetings in New England resulted in the opportunity to engage in discussions with more than 100 individuals. Audiences included State EMS officials, hospital personnel, State offices of rural health, local EMS service directors, and "street level" Emergency Medical Technicians (EMTs). The agenda for these meetings was modified from Park City to accommodate the addition of the NHTSA Workforce Assessment[1] and to allow for more audience discussion. In order to keep the meeting length to four hours and accomplish the stated goals, more printed materials concerning REMSTTAC, along with a pocket size CD-

[1] A 2 year project funded by the National Highway Traffic Safety Administration contractor through a contract with the University of California at San Francisco to describe the state of the current EMS Workforce.

ROM of the *Rural and Frontier Agenda for the Future*, were provided at registration. This strategy allowed more time for discussion among the participants and staff.

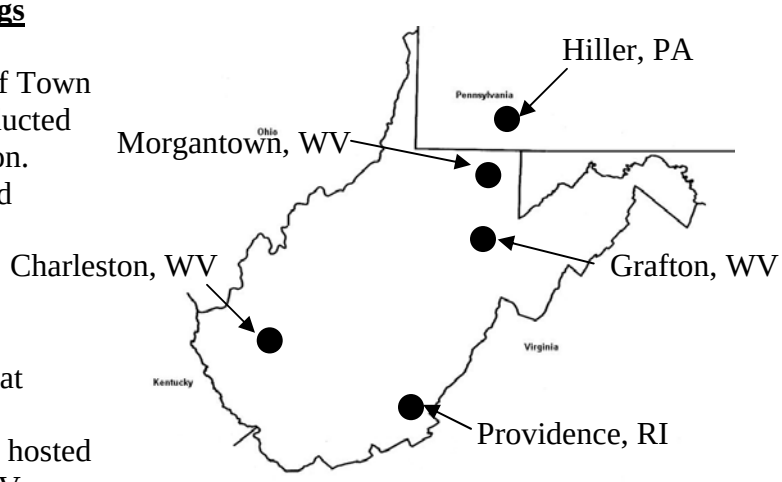
The most pressing issues identified in New England included:

Funding	Advocacy	Training
Public Education	Lack of an EMS System	Patient Transfers
Recruitment & Retention	EMS Service Management	Preparedness
Geographic Challenges		

When asked to rank and prioritize the top three challenges from the above list, participants in all four locations assigned the following ranking: 1) funding, 2) advocacy, and 3) recruitment and retention of volunteers.

Evaluations from these meetings indicated that the new format, with more time for open discussion of the issues was a positive adaptation. Again, using a modified Likert scale with 1 equaling poor and 5 equaling excellent, the mean score for meeting objectives being met were 3.91 and overall rating of the meeting was 4.35.

Appalachia Town Hall Meetings



The third and final sets of Town Hall Meetings were conducted in the Appalachian Region. These meetings were held between April 22 and April 25, 2006. Five meetings were conducted, including a televideo conference that engaged three additional locations. Meetings were hosted in Hiller, PA; Grafton WV; Morgantown, WV (included televideo connection to the towns of Boone, Braxton, and Rainelle[2]), Franklin, WV; and Charleston, WV. Dan Summers from the Center for Rural Emergency Medicine (CREM) was the local coordinator and is the representative from CREM to the REMSTTAC Stakeholder committee. At

[2] In conjunction with the meeting conducted at the West Virginia University, connections were established with three other sites via televideo. The use of this technology allowed the REMSTTAC staff to solicit more ideas and discussion as well as allowing the participants to interact from distance in real time. Evaluation results from the televideo sites reported a mean of 4.82 and 4.93 for overall meeting personal objectives and speakers presentations respectfully, which was slightly less than the actual physical site visits. Personal objectives being met had a mean of 4.93 and speaker presentations reported a mean of 4.96.

these sites, REMSTTAC again led discussions with more than 100 individuals who included physicians, nurses, EMTs, hospital administrators, rural health officials, emergency preparedness representatives, EMS agency managers, and EMS training coordinators. REMSTTAC again provided the printed material and CD-ROMs to allow as much time as possible for participants to discuss the issues.

The most pressing challenges and barriers in the Appalachia area were:

Recruitment and Retention	Funding	Training
Advocacy	Equipment Costs/Needs	Volunteers
Inequality in health care	Communications	Professional Image
EMS Service Management		

When asked to rank and prioritize the top three challenges from the above list, participants in all four locations ranked: 1) recruitment and retention 2) training and 3) professional image.

This series of meetings was highly rated with a cumulative modified Likert score of 4.93 for meeting personal objectives and 4.96 for speaker presentations.

Findings

These meetings with rural and frontier EMS providers and rural health representatives substantiate other reports and publications concerning the challenging environment facing rural EMS. The meetings also aided in contributing to dialogue between State offices of rural health and EMS agencies on the challenges of rural EMS. Evaluation comments indicated that rural EMS providers were unaware of the technical assistance and support that rural health offices could provide to their agencies. State offices of rural health also offered to support REMSTTAC activities at these meetings.

Five main challenges were identified by the participants across all venues. The items that were of greatest concern included: recruitment and retention, funding/resources, advocacy, training, and professional/self image.

DISCUSSION

Funding/Resources

In rural EMS systems, call volumes are low. However, these services still need the same basic equipment and supplies as higher volume services, thus-contributing to a high cost of readiness. The cost of readiness can be particularly high in those rural communities that choose to maintain higher levels of prehospital care personnel (e.g. EMT-Paramedics rather than EMT-Basic). Rural EMS also finds itself steered by other changes in health care delivery systems. Some rural hospitals have closed in recent years, and others have converted to Critical Access Hospitals, which has affected the costs to EMS because of more frequent, and often longer, interfacility transport times. Medicare and Medicaid reimbursements and low collection rates have affected the financial status of EMS (this was noted as particularly problematic in New England). Payment for EMS services frequently do not cover the full costs of the services performed. EMS faces funding challenges from reimbursement sources at all levels: Federal, State, and local. Even in the aftermath of 9/11 and the creation of a number of new grant programs to support emergency preparedness, the funds appropriated towards EMS preparedness activities have been limited.

Advocacy

It was noted that EMS lacks a consistent voice on all levels - Federal, State, and local. In particular, EMS needs a more consistent voice among State legislatures. Organizations need to advocate, at the State level, for EMS needs. Many individuals expressed concern that EMS has limited professional representation and is not recognized as a profession, making it very different from public health or fire departments. Participants also strongly agreed that public information and education are critical to engendering long-term support. They agreed that communities need to develop a greater understanding of the EMS system, and in particular the understanding of expectations relative to the costs of providing services. It was generally felt that most of the general public develops an "understanding" of EMS from television series that are based in urban settings, with paramedics attending to the sick and injured only minutes from a University Hospital or Level 1 Trauma Center and with state-of-the art clinical and communication equipment. This may create unrealistic expectations in rural areas that may rely solely on basic equipment, training, and other resources.

Recruitment and Retention

Since its inception, rural EMS has depended on donated hours from community members who volunteer their time to be part of the ambulance service. These individuals often pay for their own training, certification, recertification, and medical care (vaccinations, physical examinations) and are required to be serving as an active member of a local ambulance service. Across all three regional venues, it was noted that the volunteer pool is shrinking. Many felt that society is not instilling individuals with a commitment to give back to the community. Another frequently cited opinion was that the EMS volunteers often disengage from their volunteer commitments, at least in part, because of what is referred to as the "sandwich" generation -- a generation of adults who have responsibility for taking care of both their children and aging parents. Others felt that EMS is no longer attracting an appropriate pool of volunteers. EMS for years has been geared towards young men, and in particular, those who enjoy the adrenaline rush associated with a "red light and siren" response. Many felt that EMS needs to present a more realistic face to recruits because once they begin to serve they find that "it is a far cry from what is on TV." Still others expressed opinions that rural EMS is the training ground for urban systems or is utilized as a stepping stone to better paying positions such as a physician's assistant or a nurse. Once the community and EMS service have incurred the cost to train an individual for field-work, they leave for a paid position. These paid positions also have added benefits that EMS could not afford to offer such as health insurance, paid vacation, sick leave, and retirement plans. Many participants felt that there is a real need for EMS to offer greater levels of recognition to those who have served, and continue to serve, their communities, in order to encourage retention. It was noted that many times, however, the problem is simply "burnout." When both adult members of a household work and face today's combined social, educational, and economics pressures, there may not be enough time, energy, and resources to become or stay involved with EMS volunteer work.

The effect of an aging rural population was also of great concern. An aging population increases call volume, while at the same time contributing to the shrinking volunteer pool. In areas where 100 percent of EMS providers are volunteers, "this graying trend can only spell disaster." Some areas in Appalachia reported having resident populations where 80 percent or more of the people are over the age of 60 years. Many expressed a need for help with a community assessment to better educate the public and help establishing a long-term plan that describes how EMS will be provided. In some areas of West Virginia, the welfare system was reported as the primary source of income in the area. In this environment, tools must be provided to ambulance services to help retain personnel already in the system and to recruit additional personnel. More than anything else, many expressed the need for good management by agency leaders, many of whom lack formal training in this aspect of system leadership. One respondent noted, "Without this element, nothing will improve."

Training

EMS providers are required to recertify every 2 to 3 years. This requires many hours of instruction. Many rural volunteers expressed concern that they cannot afford the cost of this process. Interestingly, there was a wide variance of opinion between the need to "reduce" or "increase" training requirements, but a general consensus emerged that the cost of training needed to be offset in some fashion. Discussion about the need to reduce or offset training costs invariably was followed by dialogue regarding distance learning or the use of materials like CD-ROMs. Many felt that distance learning was the wave of the future for educating rural EMS providers. However, it was noted that in distance learning the social aspects of local squad training are lost. Additional questions arose about how to ensure EMTs achieved competence as a result of distributive learning and who would be responsible for monitoring and administering credits for completion. Others stated concerns about whether distance learning techniques would "sacrifice quality of education for quantity of education." It was noted that in many rural areas access to, and speed of, the Internet is still questionable, creating barriers to learning via distance education modalities.

Professionalism, Self Image

Some participants felt that the image of an EMT is still that of a hearse driver, who has graduated to ambulance driver, and, to some extent, has not progressed any further. TV has both helped and hindered in this regard. Television may have promoted the image of EMT-Paramedics, but the public knows little about the EMT-B, who is the dominant provider of prehospital care in much of rural America.

Participants felt that EMS needs to educate the public. EMS needs to be recognized as a profession, just as is firefighting, nursing and many other healthcare disciplines. Many felt an image change alone would help increase resources for EMS providers.

However, many felt that in order for EMS to undergo a broad-scale transformation in image, EMS will need to change from within. "We need to do background checks on individuals applying to work with EMS. EMS needs to write better job descriptions, and test for physical fitness and agility. EMS needs to stop simply accepting anyone who volunteers and be more selective." Some expressed an opinion that pervasive volunteerism has hurt the image of EMS.

Although the Town Hall meeting findings reinforce the conclusions in the *Rural and Frontier Agenda for the Future* and the IOM's *Future of Emergency Care* reports, a different conversation thread concerning EMT standards emerged. The general consensus of the collective "group" was that current standards were often too lax and that EMS needed to address professionalism within its own ranks. Participants felt that before a community's citizens, nurses, physicians, and others will assist in addressing the needs of their EMS agency, the agency needed to address the standards that they portray within their community.

CONCLUSION

The majority of time in each of the meetings was spent discussing the need to identify new funding and resources for EMS. The concept of a technical assistance center for rural EMS was overwhelmingly confirmed as one of the directions that would help with the continued success of rural and frontier EMS. At the presentation of findings to the New England EMS Council, participants agreed that comments from individuals in the field validated many ORHP and REMSTTAC programs and initiatives that are underway.

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APPENDIX A: ACKNOWLEDGEMENTS

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Teri L. Sanddal, B.S., Co-chair
Associate Director
Rural Emergency Medical Services and Trauma Technical Assistance Center

Patrick Malone, Director, Co-chair (2005)
Initiative for Rural Emergency Medical Services
University of Vermont

Dan Summers, Director of Education, Co-chair (2006)
Center for Rural Emergency Medicine
West Virginia University

Contributors and Reviewers:

Thomas J. Esposito, MD, MPH, FACS
Medical Director, REMSTTAC
Professor & Chief Section of Trauma Surgery
Department of Surgery
Loyola University Medical Center

Jacob L. Rueda III, Project Officer
U.S. Department of Health and Human Services
Health Resources and Services Administration
Office of Rural Health Policy

Nels D. Sanddal, MS, REMT-B
Director
Rural Emergency Medical Services
and Trauma Technical Assistance Center

APPENDIX B: REMSTTAC STAKEHOLDERS GROUP

Katrina Altenhofen, MPH, REMT-B
State Coordinator
Emergency Medical Services of for Children
Iowa Department of Public Health

Jane W. Ball, RN, DrPH
Executive Director (Retired)
EMSC National Resource Center
Trauma-EMS Technical Assistance Center

Bethany Cummings, DO
Rural Affairs Ad Hoc Committee
National Association of EMS Physicians

Drew Dawson, Chief, EMS Division
National Highway Traffic Safety Administration

Tom Esposito, MD
Medical Director
Rural EMS and Trauma Technical Assistance Center

Blanca Fuertes, Past Project Officer
U.S. Department of Health and Human Services
Health Resources and Services Administration
Office of Rural Health Policy

Christian L. Hanna, MPH
Michigan Public Health Institute
Child and Adolescent Health

Bob Heath, EMS Education Coordinator
Nevada State Health Division
Intermountain Regional EMS for Children Coordinating Council

Marilyn Jarvis
Assistant Director for Continuing Education
Extended University
Montana State University

Douglas F. Kupas, MD
Rural Affairs Ad Hoc Committee
National Association of EMS Physicians

Fergus Laughridge, Program Manager
Nevada State Health Division
EMS Bureau of Licensure & Certification

Tami Lichtenberg, Program Manager
Technical Assistance and Services Center
Rural Health Resource Center

Tommy Loyacono, MPA
National Association of Emergency Medical Technicians

Patrick Malone, Director
Initiative for Rural Emergency Medical Services
University of Vermont

N. Clay Mann, PhD, MS
Center Director of Research
Professor of Pediatrics
Intermountain Injury Control Research Center
University of Utah

Evan Mayfield, MS
U.S. Department of Health and Human Services
Center for Disease Control
Office of the Commissioner

Charity G. Moore, PhD
Research Assistant Professor
Cecil G. Sheps Center for Health Services Research
Univ. of North Carolina at Chapel Hill

Carol Miller, Executive Director
National Center for Frontier Communities

Kimberly K. Obbink, M.Ed, Director
Extended University
Montana State University
Jerry Overton, Executive Director
Richmond Amublance Authority

Daniel Patterson, PhD
AHRQ-NRSA Post-Doctoral Research Fellow
Cecil G. Sheps Center for Health Services Research
Univ. of North Carolina at Chapel Hill

Davis Patterson, PhD, Research Scientist
Battelle Centers for Public Health Research and Evaluation

Ana Maria Puente, Past Project Officer
U.S. Department of Health and Human Services
Health Resources and Services Administration
International Health / Office of Rural Health Policy

Jacob L. Rueda III, PhD, Project Officer
U.S. Department of Health and Human Services
Health Resources and Services Administration
Office of Rural Health Policy

Kristine Sande, Project Director
Rural Assistance Center
University of North Dakota Center for Rural Health

Mary Sheridan, Director
State Offices of Rural Health
Idaho Department of Health and Welfare

Dan Summers, RN, BSN, CEN, EMT-P
Director of Education
Center for Rural Emergency Medicine
West Virginia University

Chris Tilden, PhD, Director
Kansas Department of Health & Environment
Office of Local & Rural Health

Robert K. Waddell II
Secretary /Treasurer
National Association of EMS Educators

Bill White, President
National Native American EMS Association

Gary Wingrove, Technical Consultant
Technical Assistance and Services Center
Rural Health Resource Center

Jill Zabel Myers, Healthcare Consulting
Wipfli LLP