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Talking points from 9/20/2016 testimony for Study Committee on Volunteer EMT and Firefighter Shortages

1. Bio:
   - Employed full-time in Wisconsin EMS since 1979.
   - Current role is Director of Operations for County Rescue Services, in Brown County
   - Agency serves 21 municipalities and is primary 911 provider to approx. 100,000 population base.
   - Network with and work cooperatively with many smaller volunteer EMS services in Northeast Wisconsin.

2. EMS can be very territorial. Larger entities are sometimes viewed with distrust. Words like “consolidation” or “regionalization” are often correlated with loss of local control or the dissolution of established local agencies.

   A Different View: Pooled resources and stewardship with smaller agencies could be viewed as a more positive variant of regionalization. Larger organizations partnering with and assisting smaller agencies can be more palatable rather than a merger and acquisition thought process. There is no reason that smaller EMS organizations cannot maintain their own identity and independence yet still benefit from the guidance and support of larger entities.

   Rural EMS models in WI historically are captive to small communities or a group of municipalities. They operate in a very independent manner, recruiting and training their own people, manage their own budgets, and operate under their own medical directors and protocols. Everyone operates in their own environments and attempts to solve similar problems.

   WI has many EMS resources but perhaps they can be utilized more efficiently.

3. Break down boarders via co-operation

    a. Consider areas of shared / common Medical Control. WI Hospital Emergency Response Coalition (HERC) divides the State into seven (7) geographic districts. Often these districts contain multiple hospitals. Testimony was provided last month that quality physician medical control has been identified as a cornerstone of a quality EMS system. There is no WI rule that requires a service to name only one (1) physician as a medical director. Consider dividing the State into sectors such as the HERC districts and promote multiple physician medical directors in a district sharing the needs of, and covering a larger area or group of EMS providers. Consider the use of HERC dollars to fund and support medical directors in their area.

    b. Credential EMS personnel by geographic districts. This would allow licensed personnel credentialed within a district to freely move between services in that district. Licensed personnel could be credentialed in more than one district. Individual EMS services retain an employer/ employee relationship with EMS personnel and still vet potential EMTs prior to employing with their service.

    c. Consider temporary credential permits that a service could use to cover short / immediate staffing needs.

    d. Shared staffing via geographic recruitment. This would be broader than simply cross credentialing between agencies.

        In the most recent license period there were approximately 19,000 WI licensed EMS personnel at all levels from EMR to Paramedic. The State maintains a database of contact information for these personnel. The database can be sorted by training level, geographic area (zip-codes) or in any manner of ways. It can be examined to identify where personnel are located, how they could be accessed, and identify possible recruitment opportunities.

        Example: One rural ambulance provider was able to use this tool and identified two licensed personnel from the Fox Valley area who had vacation property in their northern township. They successfully recruited these previously unknown personnel.

e. To help facilitate district wide or geographic recruitment consider a staffing entity (resource manager) such as the Wisconsin EMS Association (WEMSA) with the clerical staff to manage the personnel database (staffing lists) and could act as a point of contact for those with a short or long term staffing need. WEMSA has been approached about the idea of acting in this capacity and has expressed verbal interest in additional information.

f. Shared staffing automatically results in shared ideas and policies and can open communication services, expanding and integrating best practices.

4. Examine NREMT records for the State. If a Nationally Registered EMT resides in the State but has not applied for a State License they may be unknown. Identify and recruit those that may not be State licensed.

    a. Example: Some levels of military medical personnel become Nationally Registered EMTs. They may not think to, or automatically seek, a State license after their military service unless prompted or recruited into the system.

5. Create a Resolution Resource Team or a group of subject matter experts that could be called upon to assist with EMS management advice, ideas, staffing suggestions or other issues. A point of contact for advice on best practices, business management issues, etc. It could simply be an EMS Manager's listserv email list that includes those willing to help others problem solve. Similar email listservs such as "Community Paramedicine" already exist and are managed by the WI Office of Rural Health. EMS managers communicating in this manner would get timely feedback on issues, and ideas would be broadcast statewide. This avoids meetings, red tape, and delays.

6. Student tuition/deferment or forgiveness for community service in protective services. Create deferred tuition opportunities for EMS education within the Technical College system. An EMS agency or municipality would sign a sponsorship form on behalf of student. Following the completion of training the new EMT, under an agreed community service contract with an EMS employer, could provide work/service hours assisting the agency. This would allow the student to enter a training program free of charge and remove the barrier of trying to recruit members with the burden of requiring them to pay for their own education. The sponsoring agency or municipality could make quarterly tuition payments to WTCS on behalf of sponsored students.

7. Allow flexible EMS staffing in times of need for smaller communities. Allow EMS services in communities with populations of under 10,000 or 20,000 the ability to downgrade their level of licensure to the next lowest level in times of need.

   Example: An AEMT service is unable to staff to the AEMT level due to a short term staffing gap. Allow the service to drop to the EMT- Basic level until such time as they are able to return to normal staffing levels.

8. Bridge ALS /Paramedic services to rural areas by advancing interagency co-operation. This would be a modification of what are now known as paramedic intercepts.

   Example: An AEMT service has an employee who is also a licensed paramedic. Through co-operation with a neighboring paramedic level service, this paramedic is employed by and on the roster of both agencies. The AEMT service carries or stocks necessary paramedic level supplies based on local protocols. If while working for the AEMT service paramedic skills are required, the medic notifies the paramedic service, requests assistance if necessary, and activates him/herself as a paramedic now functioning under the paramedic provider's license, medical control, and protocols.

   Similar arrangements could be made for EMT basic services who also employ AEMTs and work cooperatively with a neighboring AEMT service.

The above suggestions and views are as a result of my experience in Wisconsin EMS, and are not representative of any other entity or of County Rescue Services as my employer.

Please contact me if additional information is required.

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