EMERGENCY MEDICAL CARE COMMITTEE
CONTRA COSTA COUNTY

Wednesday, December 11, 2019
4:00 – 5:30 p.m.
Contra Costa County EMS Agency Office
777 Arnold Drive, Martinez, CA 94553

Agenda

4:00 p.m.	1.	Introduction of Members and Guests
4:05	2.	Approval of Minutes from September 11, 2019
4:10	3.	Comments from the Public Members of the public may speak up to 3 minutes each on matters either on or not on this agenda.
4:13	4.	Chair's Report Kacey Hansen, EMCC Chair
4:20	5.	Members' Reports Presentation of new slate of officers for EMCC Executive Committee by Nominating Committee
4:30	6.	Fire Chiefs' Report Fire Executive Chief Representative
4:40	7.	EMCC Legislative Report Emergency Nurses Association Representative
4:50	8.	Staff Report: EMCC Annual (Draft) Report Action: Review/Approve for Submission to the Board of Supervisors Rachel Morris, Contra Costa EMS – Staff to EMCC
4:55	9.	Quarterly Update on Alliance Ambulance Services Chief Terence Carey, Contra Costa County Fire Protection District
5:05	10.	Update on draft letter requesting funding for the EMS System David Goldstein, MD, Contra Costa EMS Medical Director
5:10	11.	EMS Medical Director's Report David Goldstein, MD, Contra Costa EMS Medical Director
5:25	12.	Agenda Items for next meeting: March 11, 2020
5:30	13.	Adjournment

*(I)-Informational
*(A)-Action

Reasonable accommodations can be made for persons with disabilities planning to attend the EMCC Meeting by contacting EMS Staff at least 24 hours in advance at (925) 608-5454.

Any disclosable public records related to an item on a regular meeting agenda and distributed by the County to a majority of members of the Emergency Medical Care Committee less than 96 hours prior to that meeting are available for public inspection at 777 Arnold Drive, Suite 110, Martinez, during normal business hours.

EMERGENCY MEDICAL CARE COMMITTEE
CONTRA COSTA COUNTY

MEETING MINUTES

September 11, 2019

Members Present Representing	
Executive Committee: **Jon King *Police Chiefs' Association*** **Ellen Leng *Alameda-Contra Costa Medical Association*** Michele Bell *Air Medical Transportation Provider* Terence Carey *Contra Costa Fire Chiefs' Association* Jack Clapp *Public Provider Field Paramedic* John Duggan *Ambulance Providers (CC Contract)* Mark Forrette *District II* Pat Frost *EMS Agency Director* David Goldstein *EMS Agency Medical Director* Elaina Petrucci Gunn *American Heart Association* Cameron Metzger *EMS Training Institution* Denise Pangelinan *Communications Center Managers' Assoc.* Karin Schnaider *District III* Jason Vorhauer *Contra Costa Office of the Sheriff*	STAFF PRESENT Marshall Bennett *Contra Costa County EMS* Mia Fairbanks *Contra Costa County EMS* Ben Keizer *Contra Costa County EMS* Rachel Morris *Contra Costa County EMS* Gia Prado *Contra Costa County EMS* OTHERS PRESENT Michael Johnson *American Medical Response* Bhavin Mehta *Falcon CCT* Chad Newland *American Medical Response* Jill Ray *District II* Hannah Robbins *Alameda-Contra Costa Medical Association* Rebecca Rozen *Hospital Council of Northern and Central California*
Members Absent Representing **Chair: Kacey Hansen *Trauma Center (CC Contract)*** Ara Gregorian *California Highway Patrol* James Lambert *Hospital Council Bay Area Division* David Lilienstein *Emergency Dept. Physicians (CC Receiving Hospital)* Jennifer Lucas *American Red Cross* David Samuelson *Emergency Nurses Assoc. East Bay* Allan Tobias *District IV*	

Executive Committee Member Leng called the meeting to order at 4:05 p.m.

1.	*Introduction of Members and Guests* Meeting members and guests observed a moment of silence in honor of the 9/11 anniversary.
2.	*Approval of Minutes from June 12, 2019* Member Vorhauer motioned to approve the Minutes from June 12, 2019. Member King seconded; none opposed. Motion passed. June 2019 minutes are approved.
3.	*EMS Medical Director's Report - David Goldstein, MD, Contra Costa EMS Agency Medical Director* Member Goldstein reported fourth quarter training is coming up and gave a brief overview of changes, including adding two new medications for ALS and BLS scopes; changing a significant piece of airway equipment from King airway to i-gel; adding hemostatic gauze in the Spring.
4.	*Comments from the Public* No Comments
5.	*Chair's Report* No Report
6.	*Members' Reports* Presentation of new slate of officers for EMCC Executive Committee – staff support Morris requested a motion to delay the nominations for new officers to the December meeting. More time is needed to identify who is going to be nominated Member King motioned to delay the nominations for new officers to the December meeting. Member Forrette seconded; none opposed. Motion passed. Both medical and non-medical members were encouraged to participate on the Executive Committee.
7.	*Health Care Coalition Biannual Report to EMCC – Lisa Vajgrt-Smith, Contra Costa Emergency Preparedness Coordinator* Health Services staff Lisa Vajgrt-Smith provided the biannual report of Contra Costa Med-Health Preparedness Coalition (HPP Emergency Preparedness) activities. Report highlights include continued efforts trying to onboard more coalition members; developments of the MHPC Response Plan and MHOAC Guide; held incident command training for SNFS; in April held Hazmat

	full scale exercise involving participation from all eight hospitals testing the systems response to a cyanide exposure. The largest deliverable for HPP was creating the Med Health Preparedness Coalition Response Plan & MHOAC guide. This is a hybrid document that is meant to assist the Operational Area with response coordination. The MRC has been very active; deployed to the Butte and Camp fires as part of responses. The MRC was awarded a 20,000 dollar grant to work with national MRC to come up with training standards.
8.	*EMCC Legislative Update* Member Samuelson (ENA representative) not present. Member Frost referred to a copy of a letter in the meeting materials packet regarding AB 1544; Contra Costa County is in support of alternative destinations. It has been an active legislative season with various groups trying to move legislation. It is important to keep patient care as the main priority.
9.	*Fire Chiefs' Report – Chief Terry Carey, Contra Costa County Fire Protection District (CCCFPD)* -Reached agreement for CCCFDP to partner with REACH. As of 9/28/19, will have two staffed aircraft based out of Concord. Aircraft will be staffed with both REACH and CCCFPD personnel. -On 9/14/19 there will be line of duty death ceremony at CCCFPD from 10:00-11:30. This is an annual event and all are welcome to attend. -CCCFPD is having an open house on 11/2/19 at the Training Center. -Participated with law enforcement partners from 9/3 to 9/6 in an active shooter drill at John Muir.
10.	*Quarterly Update on Alliance Ambulance Services – Chief Terry Carey, Contra Costa County Fire Protection District (CCCFPD)* -Continuing to work on wall time issues, trying to come up with innovative solutions on how to free up ambulances more quickly. Reached an agreement with County; agreement included purchase of a new gurney so an occupied gurney can be switched out, if needed. -Dips experienced in compliance numbers. The threshold is 90 percent; haven't gone below the threshold but have experienced challenge. Improvements have been made, including increased staffing, allowing compliance numbers to stay closer to 95 percent. -Sonoma County EMS stakeholders visited Contra Costa County to learn more about the Alliance model; meeting was well received. -AMR staff Chad Newland reported on deployed personnel responding to Hurricane Dorian; locally sent three people and all came back safely.
11.	*Discussion and Request for Letter of Support for Additional EMS System Dedicated Funding* Member Frost addressed the Committee; the EMCC has been updated over the last 18 months on reports to the County Finance Committee on EMS system funding. As reported Measure H funds are the only dedicated funding supporting enhancement of the County's high-performance EMS System. Measure H funding was established over 40 years ago with no cost of living adjustment built in. Since then costs have increased and it has been reported to the finance committee that additional funds are required. The Agency was successful in getting a onetime allocation of 550,000 dollars, with direction from the Finance Committee, Chairs Supervisors Gioia and Mitchoff, to determine interest in EMS stakeholders supporting a ballot measure to support future EMS System funding. The Agency is requesting a letter of support for dedicated EMS System funding from the EMCC to the BOS. A motion was made to support a letter of support in concept; however, that motion did not pass. After more discussion, it was suggested that a draft of the requested letter be composed and reviewed by the EMCC prior to voting on moving it forward to the BOS on behalf of the EMCC. The Committee would like to review the letter a month prior to the next scheduled EMCC meeting, scheduled for December 11, 2019. Member King motioned to have Member Frost draft a letter of support for EMS System Funding to be reviewed by the EMCC three to four weeks prior to next EMCC meeting. Member Vorhauer seconded; none opposed. Motion passed.
12.	*EMS Director's Report –Pat Frost, Contra Costa EMS Agency Director* - Ambulance Ordinance – Still in progress; anticipated scheduling of stakeholder workshop before end of year to review before bringing to BOS. - San Ramon RFP – current contract to be extended through April 30, 2020; still some ambiguity on the interpretation of 201/224 rights. - EMS Authority (EMSA) Updates – there is a new interim Acting Director, Julie Souliere CHHS Assistant Secretary. EMSA retroactively denied our system plan and have denied our current system plan. We are still waiting to hear back on the appeal and to get a hearing date. The area of denial is associated with the transportation part of the plan. A number of long-standing guidelines LEMSAs have been required to use as part of system planning and exclusive operating area procurement have been taken down after allegations of underground regulation were made by Cal Chiefs, and it is unclear what the next steps will be. -No update on closure of Alta Bates. Efforts are still being made in Alameda County. -PG&E power shutoffs – public education being conducted which shifts the preparedness responsibility to the community.
13.	*Proposed agenda item(s) for December 11, 2019:* Presentation of new slate of officers; Review and vote on draft letter of support for funding letter.
14.	*Adjournment at 5:39pm*

EMCC Attendance 2018-2020

Seats	EMCC Members	12/12/2018	3/13/2019	6/12/2019	9/11/2019	12/11/2019	3/11/2020	6/10/2020	9/9/2020
B 1 Alameda Contra Costa Medical Association	Ellen Leng	Present	Present	Present	Present				
B 2 American Heart Associaton	Elaina Petrucci Gunn	Absent	Present	Absent	Present				
B 3 American Red Cross	Jennifer Lucas	Absent	Present	Absent	Absent				
B 4 California Highway Patrol	Ara Gregorian	Absent	Absent	Absent	Absent				
B 5 Communications Center Managers' Association	Denise Pangelinan	Absent	Present	Absent	Present				
B 6 Contra Costa Fire Chiefs' Association	Terence Carey	Present	Present	Present	Present				
B 7 Contra Costa Police Chiefs' Association	Jon King	Present	Present	Present	Present				
B 8 Emer. Nurses Assoc. East Bay Chapter	David Samuelson	Absent	Present	Present	Absent				
B 9 Hospital Council East Bay	James Lambert	Absent	Present	Present	Absent				
B 10 Public Managers' Association	Vacant	Present (Napper)	Present (Napper)	Present (Napper)	Vacant (Napper Resigned)				
B 11 Trauma Center (Contra Costa Contract)	Kacey Hansen	Absent	Absent	Present	Absent				
B 12 Contra Costa Office of the Sheriff	Jason Vorhauer	Present	Absent	Present	Present				
B 13 Contra Costa Health Services - Behavioral Health	Vacant	Vacant	Vacant	Vacant	Vacant				
C 1 Ambulance Providers (Contra Costa Contract)	John Duggan	Present	Present	Present	Present				
C 2 Air Medical Transportation Provider	Michele Bell	Present	Present	Present	Present				
C 3 EMS Training Institution	Cameron Metzger	Present	Present	Absent	Present				
C 4 Private Provider Field Paramedic	Vacant	Vacant	Vacant	Vacant	Vacant				
C 5 Public Provider Field Paramedic	Jack Clapp	Absent	Present	Present	Present				
C 6 Emergency Department Physicians	David Lilienstein	Absent	Present	Present	Absent				
District I (Gioia)	Vacant	Absent (Stieler)	Absent (Stieler)	Vacant (Stieler Resigned)	Vacant				
District II (Andersen)	Mark Forrette	Present	Present	Absent	Present				
District III (Burgis)	Karin Schnaider	Absent	Present	Present	Present				
District IV (Mitchoff)	Allan Tobias	Absent	Absent	Present	Absent				
District V (Glover)	Vacant	Vacant	Vacant	Vacant	Vacant				
E 1 Ex Officio	Pat Frost	Present	Present	Absent	Present				
E 2 Ex Officio	David Goldstein	Present	Present	Present	Present				
	Quorum								

Advisory Body + Brown Act done

Meeting Attendance Requirements per the Bylaws:

A. EMCC members shall attend EMCC meetings.
B. A member who cannot attend a meeting must notify the Chair and may have one excused absence in a twelve month period.
C. Whenever a member does not attend two regularly scheduled meetings, within a rolling twelve month period, complete their Brown Act requirements or fails to meet the criteria for sitting on the advisory body the EMS Agency shall notify the nominating agency/organization of the absences and request appropriate action.
D. Members must complete the required Ethics and Brown Act training provided by the County within three months of appointment and submit the "Training Certification for Member of County Advisory Body" form to EMS staff prior to participating at any meeting.
E. Members who do not complete the Ethics and Brown Act training within 3 months may not further participate until the requirement is fulfilled.
F. Ethics and Brown Act training is recommended to be completed every two years while serving on a County Advisory Committee.

Annual Report for 2019

Advisory Body Name: Emergency Medical Care Committee (EMCC)
Advisory Body Meeting Time/Location: 4:00 p.m. - 5:30 p.m. on the second Wednesday of March, June, September, and December, unless otherwise noted. Meetings are held at the EMS Agency office, 777 Arnold Drive, Suite 110, Martinez, unless otherwise noted.
Chair: Kacey Hansen (December 2015 – December 2019)
Staff Person: Rachel Morris (January 2017 – Present), Health Services, Emergency Medical Services
Reporting Period: January 1, 2019 – December 31, 2019

I. Activities:

The EMCC, over four (4) regular meetings in the past year, was involved in or kept its membership informed about the following:

- Alliance annual report was given with discussion at the Board of Supervisors on ambulance patient offload times (APOT) impact on EMS system and providers.
- Local EMS Agency (LEMSA) establishes optional scope for use of epinephrine and narcan in first responder BLS protocols. Once established, new protocols created an opportunity for all BLS fire first responder agencies to use.
- The continued process to update the county ambulance ordinance. Final draft ambulance ordinance released from County Counsel. EMCC Stakeholder Workshop anticipated prior to bringing the ordinance to the Board of Supervisors. Updates in ordinance are focused on non-emergency ambulance services and public safety, and integration of emergency and non-emergency transport providers in mass casualty and disaster events.
- LEMSA participation with CCHS partners and system stakeholders on opiate overdose workgroup.
- The Board of Supervisors recognized May 19-25th 2019 as National EMS Week, and May 22nd as EMS for Children Day.
- Monitor the continued status of potential closure of Alta Bates Hospital, Alameda County and City of Berkeley workgroup, and concerns of impact to West County.
- San Ramon RFP contract extended by the Board of Supervisors to April 30, 2020.
- EMSA approved EMS for Children (EMSC) regulations; LEMSA staff working on the local efforts for Contra Costa EMS for Children system of care.
- On November 20th, EMS hosted the 4th annual Contra Costa County Survivors Reunion Luncheon to show tangible continuum of care, and where survivors meet their rescuers.
- Treatment guidelines and policies updated towards the end of a year are mostly finished for sending out for public comment. Implementation is January 1st, 2020.
- The LEMSA along with other Contra Costa County divisions, stakeholders and outside agencies, all worked together during the PG&E Public Safety Power Shutoffs (PSPS).
- Biannual activity reported for the Contra Costa Med-Health Coalition to comply with Hospital Preparedness Program (HPP) program requirements.
- Continued adverse impacts on 9-1-1 ambulance providers and patient care associated with prolonged ambulance patient offload delays (APOT).
- LEMSA reports to Board of Supervisor Finance Committee addressing needs for sustainable EMS System funding to support continuity of operations of a high-performance EMS system.
- EMSA denials of Contra Costa 2016 & 2017 EMS system plans and appeals associated with the County Alliance procurement process in 2014.
- Launch of Contra Costa Community College Paramedic Program.
- Appointment of Dr. David Goldstein as new interim EMS Director.

II. Accomplishments

- Approval of EMCC 2018 Annual Report.
- LEMSA recognized with the Mission Lifeline: Gold Plus Award for their STEMI system, along with AMR Concord, CCCFPD, ECCFPD, El Cerrito Fire Department, MOFD, Pinole Fire Department, Richmond Fire Department, Rodeo-Hercules Fire District, SRVFPD.
- Recognition of the AMR Contra Costa Team for their response to disasters during the past five (5) years.
- New Slate of Officers nominations, elections, and appointments for the 2019-2021 term.

III. Attendance/Representation

The EMCC is a multidisciplinary committee with membership consisting of representation of specific EMS stakeholder groups and organizations plus one (1) consumer member nominated by each Board of Supervisor member. There are twenty-one (21) filled member seats on the EMCC. Three (3) seats are unfilled. A quorum was achieved at four (4) of the four (4) EMCC meetings in 2019.

IV. Training/Certification

Each EMCC representative was given a copy of the Advisory Body Handbook and copies of the "The Brown Act and Better Government Ordinance Training Video" and "Ethics Orientation for County Officials" video (updated to "Ethics for Local Government Officials" video offered by the Fair Political Practices Commission) during their two (2) year term. Responsibilities of County Boards were discussed including the responsibility to view the videos and submit signed certifications. Certification forms have been received from 13 of 21 of the representatives. The two certificates received this year are attached.

V. Proposed Work Plan/Objectives for Next Year

Report to the local EMS Agency and to the Board of Supervisors as appropriate its observations and recommendations relative to its review of:

- Continue to support and foster Alliance/EMS partnerships to enhance efficiencies and workflows supporting EMS System improvement.
- Continue to explore opportunities and efforts to procure sustainable funding for EMS System emergency communications, dispatch and data infrastructure enhancements to optimize patient care in day to day and disaster conditions.
- Support Medical Health Disaster Coalition preparedness and engagement throughout EMS System in accordance with CMS Emergency Preparedness provider requirements.
- Engage stakeholders in supporting Medical Reserve Corps' capability for children and special needs populations.
- Approve new county ambulance ordinance.
- Continue to support LEMSA EMS System Plan(s) and Alliance procurement appeals to EMS Commission.
- Receive updates on State EMS Authority the 2018 EMS System Plan, Quality, Trauma, Stroke, STEMI and EMS for Children programs.
- Continue to monitor and report on EMS System impacts due to changing economics and health care reform.
- Receive 2018 Annual EMS System performance report.
- Support exploration on innovative models of EMS service delivery with hospital community.
- Support emergency ambulance provider and community hospitals efforts to reduce patient transfer of care extended delays that impact the availability of ambulances for the next 9-1-1 call.
- Support EMS System program (STEMI, Stroke, Cardiac Arrest, EMSC, Quality/Patient Safety and Trauma) initiatives.
- Support and sustain community education and outreach, e.g. *HeartSafe*, Child Injury Prevention.
- Support appropriate use of 9-1-1, CPR Anytime, and Automatic External Defibrillator (AED) programs through partnerships with law enforcement, CERT, fire first responders and community coalitions.
- Continue to support 5thth Annual Contra Costa Survivors Reunion.
- Continue to monitor West County EMS System associated with closure of Doctors Medical Center and pending closure of Alta Bates Summit.
- Receive updates on the Contra Costa Med/Health Coalition as required by the Contra Costa Med/Health Coalition Charter.
- Receive updates on status of Community Paramedic and EMT training programs.
- Receive updates on treatment guidelines and policies for 2020.
- Receive updates on EMS Quality Partnership tool "First Pass" supporting enhanced provider level compliance associated with prehospital patient care workflows.

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FOR IMMEDIATE RELEASE

Ambulance Companies Receive Statewide Award for Innovation and Quality

SACRAMENTO, CA, September 13, 2019 - The California Ambulance Association is thrilled to announce the recipients of the 2019 California Ambulance Association Service Excellence (CAASE) Awards. The CAASE awards recognize excellence, resourcefulness, and ground-breaking ideas being implemented by California ambulance operators and showcase the best practices of the ambulance business in the state. Award recipients are: American Medical Response, Contra Costa County; Hall Ambulance Service, Bakersfield; Medic Ambulance Service, Vallejo; Riggs Ambulance Service, Merced.

A panel of independent judges reviewed all of the submissions and scored the programs. As a result, seven awards will be presented at the CAA Annual Convention and Reimbursement Conference on September 25, 2019 in San Diego.

Those ambulance companies receiving the awards include:

Category: Community Impact

American Medical Response, Contra Costa County – **Enhanced Bystander CPR**

Recognizing that early bystander CPR and AED usage can dramatically reduce morbidity and mortality associated with sudden cardiac arrest, and that often it is a lack of training or comfort with their training that prevents lay rescuers from performing CPR; AMR implemented an enhanced bystander CPR program designed to increase lay rescuer comfort with performing CPR as well as improve familiarity with how to properly use an AED. In the year prior to EBCPR, bystander CPR rates for Sudden Cardiac Arrest were 41.9% and Public AED usage was 6.6%. Following EBCPR, bystander CPR rates increased to 49%, and Public AED usage increased to 11.3%.

Category: Clinical Service/Patient Outcomes

American Medical Response, Contra Costa County – **CPR HD**

During 2017, AMR experienced 3 sentinel events that served as an impetus to do an in depth review of cardiac arrest management in the county. A drop in cardiac arrest survival percentage was noted in the CARES data from 38.5%1 (2016) to 28.6%1 (2017). In addition to the drop in survival rates, review of the CodeStat analysis showed that as a system, providers lacked a uniform approach to cardiac arrest management. The lack of a uniformed approach put our providers at risk for injury and our patients were not receiving optimal care. The solution brought forth was to create a uniformed approach/ system to cardiac arrest management that could replicated throughout our service area. That system is called CPR Highly Defined or CPR-HD.

Hall Ambulance Service, Bakersfield – **HP CPR and AutoPulse**

Hall Ambulance's focus on high-performance CPR changed the mindset of the paramedics, EMTs, RNs, and firefighters. In 2015, their ROSC rate was 16%. CPR was looked at as something that had to be done but didn't really help the patient. Because of the concentrated training and information shared through the report cards, their crews and the firefighters see it as a tool that is useful and actually does save lives. Now their ROSC rates are 34% because they are just doing better! Hall Ambulance's commitment to high-quality CPR did not end with the implementation of the AutoPulse. In August 2019, Hall Ambulance purchased new CPR mannequins that give real-time feedback to the first responders on rate and depth of compressions, as well as the quality of assisted ventilations. Using these mannequins, Hall Ambulance will be able to monitor the effectiveness of every compression and ventilation as it is provided to the mannequin. This will allow students to gain a better feel for correct CPR mechanics. Additionally, the equipment will be able to provide a report card to the student to verify their successful performance in class.

Category: Innovation in EMS

American Ambulance, Fresno – **Perfect Posting Software**

Each day, PerfectPosting makes roughly 2,000 deployment decisions for the 100+ vehicles online. It uses an interface with GoogleMaps API to generate real-time travel estimates in each scenario and delays associated with recent crew downtime, in-motion vs. at post units, and hundreds of other rules in their decision trees. It makes these decisions fairly and consistently, based on a rigorously documented set of rules. When possible, it automatically places units out of service to finish their shift on time, thereby practically eliminating shift holdovers. Key among the benefits is an accurate account of downtime for each crew during their shift. When the activity data shows that a crew was unable to have a required 30 minute meal period, the system automatically generates a one-hour payment for payroll. This system has made a significant impact on their ability to protect their employees from excessive fatigue, to apply consistent rules every minute of every day and increase their ability to comply with the ever changing California labor laws.

Hall Ambulance Service, Bakersfield – **EMS Academy**

To combat the issue of the shortage of EMS workers, Hall Ambulance began exploring methods to expand its career pathways for their recruits to become EMTs and EMTs to become paramedics and establish a standalone training center to enhance their other internal training programs. To accomplish this Hall expanded its long standing private-public partnership with Bakersfield Community College to create a Hall Paramedic Academy in which Hall EMTs would be paid to complete their paramedic education. Hall has operated an EMT Academy partnership with Bakersfield College that has yielded quality students with extremely high National Registry pass rates.

Medic Ambulance Service, Solano County – **CPR Coalition**

Beginning in January 2018, Medic Ambulance and Fairfield Fire Department engaged in a clinical outcome project with the goal of improving survival rates and Return of Spontaneous Circulation (ROSC). The agencies' operational and clinical leaders met regularly to review data and

determine where they could impact change. They then recruited the only receiving hospital for the City of Fairfield, NorthBay to the team. All three entities agreed to send representatives to the Resuscitation Academy put on by Seattle Fire to learn the team approach and physiological understanding of why the approach is successful. Basically, it boils down to high quality CPR, minimal pauses and community approach to CPR from the point of call to on scene to transport to arrival at the hospital. Medic Ambulance had had a total of 8 patients from March 1, 2019 to August 31, 2019 experience Return of Spontaneous Circulation or ROSC, as compared to 3 patients during the same time frame last year.

Riggs Ambulance, Merced – **BLS Tiered Response System**

According to the EMS Agenda of 2050 one of the most important principles of an EMS system is that it be innovative. In May 1, 2018, after many discussions and planning sessions, under the direction of Carly Alley, the Executive Director of Riggs Ambulance Service, Riggs launched a BLS tiered response system. This new BLS tiered response has increased the quality of care that EMTs began providing and it also inspired more than a handful of EMTs to begin Paramedic school. This also helped Band-Aid staffing issues with the addition of BLS cars to a very busy ALS system.

Details about each award-winning program are posted on the CAA's website at http://www.the-caa.org/CAASEAWinners.asp . Congratulations goes out to the inaugural winners of the CAASE Awards! Each of these companies are deserving of recognition for their innovation, commitment to their communities, and extraordinary service.

Ambulance companies willing to share their knowledge and ideas with their colleagues is the ideal way to demonstrate a company's commitment to excellence. By sharing these achievements, these companies help to set the bar for everyone else in California. Sharing this information improves California's ambulance industry and strengthens the profession.

The California Ambulance Association (CAA) represents providers of emergency and non-emergency medically necessary transportation services throughout the State of California. Since its founding in 1948, the objectives of the CAA have been to promote better patient care, develop the highest level of ambulance services, cooperate with organizations providing medical care to the citizens of California, seek to improve standards for personnel and equipment, and encourage the highest standards of ethics and conduct.

RESEARCH HIGHLIGHT

Healthforce Center at UCSF

Key Findings from Evaluation of Health Workforce Pilot Project #173 – Community Paramedicine

Janet Coffman, PhD, MPP, Cynthia Wides, MA, Lisel Blash, MPA, Ginachukwu Amah, Matthew Niedzwiecki, PhD
Philip R. Lee Institute for Health Policy Studies and Healthforce Center at UCSF

August 29, 2019

Introduction

Community paramedicine, also known as mobile integrated health (MIH-CP) is an innovative model of care that seeks to improve the effectiveness and efficiency of health care delivery by using specially trained paramedics in partnership with other health care providers to address the needs of local health care systems. In November 2014, the California Office of Statewide Health Planning and Development (OSHPD) approved an application from the California Emergency Medical Services Authority (EMSA) to establish a Health Workforce Pilot Project (HWPP) that has encompassed projects testing seven different community paramedicine concepts. Fifteen projects are currently enrolling patients.

EMS agencies that operate pilot projects provide these services in addition to 911 response services. Agencies are not permitted to divert resources from 911 response to provide community paramedicine services. Consistent with requirements for all services EMS agencies provide, community paramedicine pilot projects are also required to serve all eligible persons regardless of their race/ethnicity, gender, age, or type of health insurance.

The HWPP regulations require organizations that sponsor pilot projects to retain an independent evaluator to assess trainee performance, patient acceptance, and cost effectiveness. The Philip R. Lee Institute for Health Policy Studies and Healthforce Center (formerly the Center for the Health Professions) at the University of California, San Francisco, are conducting an evaluation of the community paramedicine pilot projects funded by the California Health Care Foundation. This document provides an overview of the evaluation and summarizes major findings. The latest full report on the evaluation is available here.

Evaluation Methodology

The primary objectives of the evaluation are to assess the safety and effectiveness of the pilot projects and to estimate their potential to yield savings for health plans and health systems.

Safety and Effectiveness

- The evaluation contains extensive information about the safety and effectiveness of the pilot projects.
- Every project has a project manager, a medical director who is an emergency medicine physician, and a quality assurance officer who is most often a registered nurse whose specialty is emergency nursing.
- The pilot projects review records for 100% of the patients they enroll to monitor patient safety.
- Sites are required to report unusual occurrences to EMSA's project manager.
- The independent evaluator reviews data provided by sites for the evaluation and shares any concerns about patient safety that emerge from the data with EMSA and OSHPD.

Cost Analysis

- The independent evaluator conducted an analysis of incremental costs incurred by participating EMS providers. Costs that EMS providers would incur regardless of whether they were participating in the pilot project, such as dispatching ambulances for 911 calls, were not included.
- Estimating costs for labor and vehicles across the pilot projects is difficult due to differences in how projects are staffed, generosity of employee benefits, and the manner in which each site allocates costs for vehicles, supplies, etc., to the pilot project activities.
- The evaluation was designed to estimate the potential of the pilot projects to yield savings for health plans and health systems. It was not designed to assess the cost effectiveness of the pilot projects. Mature programs in other states have been able to demonstrate cost effectiveness.

Dissemination and Use of the Evaluation

- All data received from the sites are included in the quarterly reports that the evaluator submits to OSHPD. Only the evaluator, not EMSA, receives data from the project sites.
- A report summarizing findings from the evaluation for the first year in which the pilot projects were in operation was released in January 2017. Updates to the initial report were released in February 2018, July 2018, and February 2019 The latest update to the report was released on August 6, 2019, and is available here.
- Findings from the quarterly reports and the annual reports on the evaluation are shared with EMSA which has used the findings to make decisions regarding the pilot projects.
    - EMSA discontinued the alternate destination – urgent care projects because the evaluation found that enrollment was low.
    - EMSA required Butte's post-discharge project to change its protocol to provide a home visit to every patient enrolled because the evaluation found that the other four post-discharge projects, all of which provided a home visit to every patient, had better outcomes.

General Findings

Safety

- None of the pilot projects have resulted in any adverse outcomes for patients.

Collaboration with Other Health Professionals

- In all projects, paramedics collaborate with registered nurses (RNs), mental health professionals, social services providers, and other health professionals. They do not replace any other healthcare personnel.

Enrollment

- Each of the pilot projects was implemented in response to local needs and serves people with specific health care needs within specific parts of the healthcare system. Projects were designed at the local level by the local EMS authority, emergency (911) response partners, and health care delivery system partners to meet the needs of specific groups of people in their communities.
- Due to large differences in the demographic characteristics of people in different regions of California, the demographic characteristics of persons served by the pilot projects should not be expected to reflect the demographic characteristics of California's overall population.
- There are multiple reasons why the numbers of patients enrolled by pilot projects have been lower than the numbers that sites projected in their applications. These reasons include
    - The data that were available to pilot sites to estimate the number of people who would be eligible to enroll in the pilot projects were limited.
    - Some sites have had staffing challenges that have prevented them from offering community paramedicine services to all eligible patients.
    - All patients are offered the option to accept or decline enrollment. Some eligible people have chosen not to enroll.

Concept Specific Findings

Alternate Destination – Mental Health Crisis Center

- The three alternate destination – mental health project enrolled 2,045 persons between September 2015 and March 2019.
- Persons enrolled in the alternate destination – mental health projects receive care from a mental health professional more quickly than persons with mental health needs who were not enrolled in one of the pilot projects because they do not have to first go to an ED for a medical evaluation and then be transported to a mental health crisis center.
- Stanislaus' pilot project only enrolls Medi-Cal beneficiaries and uninsured persons because the mental health crisis center that participates in the pilot project is operated by Stanislaus County and only accepts Medi-Cal

beneficiaries and uninsured persons. The other two Alternate Destination – Mental Health projects enroll all eligible patients regardless of insurance status.

- The rate at which patients transported to mental health crisis centers are transported to an ED within six hours of admission is low.
    - Only 2% of the patients transported to a mental health crisis center (47 of 2,045 patients) had a secondary transport to an ED.
    - Only four patients were admitted to a hospital for inpatient medical care; all others were treated in an ED and released or transferred to a psychiatric facility.
    - The savings associated with transporting 1,998 patients directly to the mental health crisis center without first transporting them to an ED for medical clearance exceeds the costs associated with secondary transports to an ED for 47 patients.

Alternate Destination – Sobering Center

- San Francisco's alternate destination – sobering center project enrolled 1,627 persons between February 2017 and March 2019.
- RNs on the San Francisco sobering center's staff monitor acutely intoxicated patients closely and focus exclusively on their needs.
- The evaluation is collecting data on the number of people transported to San Francisco's sobering center who are turned away by RNs on the sobering center's staff.
    - From February 2017 through March 2019, the staff refused to admit only 2 of the 1,627 patients transported to the sobering center.
    - In both cases, the patients were refused because they did not meet the sobering center's criteria for admission.
    - Both patients were transported to an ED, treated, and released.
- The rate at which patients transported to San Francisco's sobering center are transported to an ED within six hours of admission is low.
    - Only 2% of the patients transported to San Francisco's sobering center (32 of 1,627 patients) had a secondary transport to an ED.
    - Only two patients were admitted to a hospital for inpatient medical care; all others were treated in an ED and released or transferred to a psychiatric facility.
- The savings associated with transporting 1,593 patients directly to the sobering center instead of first transporting them to an ED for medical clearance exceed the costs associated with secondary transports to an ED for 34 patients.
- The intensity of case management and supportive services available to acutely intoxicated persons treated at the sobering center is greater than the intensity of services provided by EDs in San Francisco.

Post-Discharge

- The five post-discharge projects enrolled 1,758 people between June 2015 and March 2019.
- The one post-discharge project for which patients have a higher rate of hospital readmission within 30 days of discharge than the hospital's historical rate originally did not offer home visits to all patients. EMSA required this project (Butte) to revise its protocol to visit every patient in his or her home at least once unless the patient declines.
- Persons enrolled in the four post-discharge projects that have always provided a home visit to every patient (Alameda, San Bernardino, Solano, and UCLA – Glendale) have 30-day readmission rates that are lower than their partner hospitals' historical readmission rates except for persons enrolled in Alameda's project who have chronic obstructive pulmonary disease.
- The quarterly reports that the evaluator provides to OSHPD and the public reports on the evaluation include data on revisits to an ED within 30 days of hospital discharge and note differences between the site that originally did not offer home visits (Butte) to all patients and the four sites that did.
- The rates of ED revisits reported in the quarterly reports to OSHPD are for all ED revisits regardless of whether those revisits resulted in readmission to an inpatient ward.
- The public report on the evaluation does not compare the impact of the post-discharge projects on repeat visits to the ED and placement of patients on observation status because the project lacks a source of readily available historical data on repeat ED visits and use of observation status at hospitals participating in the pilot projects. Comparisons that rely on data from other hospitals may not reflect the actual experience of participating hospitals.

Frequent EMS Users

- The three Frequent EMS user projects enrolled 260 persons between July 2015 and March 2019.
- All three Frequent EMS user projects utilize community paramedics on a full-time basis. When these paramedics are working as community paramedics they are not scheduled to respond to 911 calls. They only respond if a 911 call involves one of their clients.
- The Frequent EMS user projects link clients to organizations that provide a wide range of services including medical care, mental health services, drug and alcohol treatment, food assistance, housing assistance, transportation assistance, and domestic violence resources.
- In December 2016, the community paramedics working on San Diego's project were reassigned to traditional 911 response crews. Their employer was experiencing difficulties meeting contractual obligations for 911 response and determined that all paramedics needed to be assigned to 911 response crews. According to San Diego management, these difficulties were not due to the community paramedicine pilot project. The project was relaunched in June 2019.

Hospice

- Ventura County's hospice project enrolled 363 people between August 2015 and March 2019.
- Since this is a pilot project, Ventura County's EMS agency only partners with a small number of hospices with which it has close relationships.
- The community paramedics support RNs who work for partner hospices by responding rapidly to 911 calls. If a hospice RN is not already on scene, the community paramedic who responds to the call contacts a hospice nurse who provides guidance on how to care for the patient.
- The hospice project has reduced the percentage of hospice patients transported to an ED from 80% to 27%.
- For Ventura's hospice project, the evaluation used a higher baseline rate of transports of hospice patients who called 911 than the rate Ventura reported in its application to participate in the pilot project. Subsequent to submission of the application, Ventura conducted a more thorough electronic search of its records of 911 calls. That analysis identified additional 911 calls that involved transport of hospice patients to an ED.

Directly Observed Therapy for Tuberculosis

- Ventura County's directly observed therapy for tuberculosis project enrolled 49 people between June 2015 and March 2019.
- The community paramedics who participate in Ventura's directly observed therapy for tuberculosis project receive direction from the county's tuberculosis control physician and RN manager.
- The community paramedics who participate in Ventura's directly observed therapy for tuberculosis project have not displaced any community health workers. Ventura County has not terminated nor has it reduced the hours of any community health workers employed by the tuberculosis control program. Paramedics complement community health workers, enabling Ventura County to provide directly observed therapy to more people with tuberculosis.
- The community paramedics dispensed 99.95% of doses prescribed by the tuberculosis control physician due to their availability after hours and weekends and their ability to serve people in all parts of the county.

Alternate Destination – Urgent Care Center

- The three alternate destination – urgent care projects enrolled 48 people between September 2015 and September 2017.
- EMSA cancelled the alternate destination – urgent care projects due to the low enrollment which made it impossible to conclusively evaluate the safety and effectiveness of the concept and to estimate the potential for this approach to yield savings for health plans and health systems.

Acknowledgements

Funding for this project was provided by the California Health Care Foundation.

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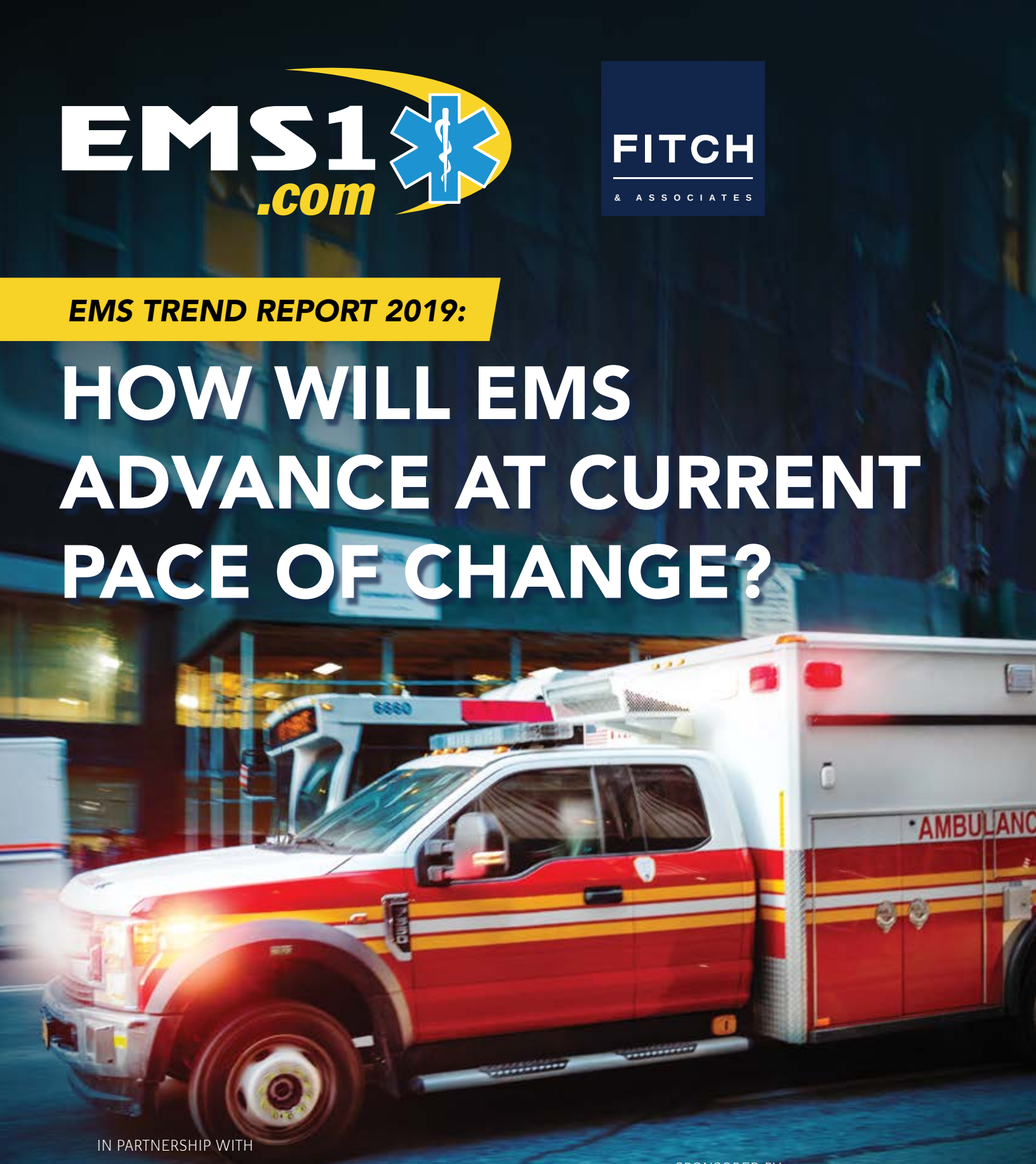
EMS TREND REPORT 2019:

HOW WILL EMS ADVANCE AT CURRENT PACE OF CHANGE?



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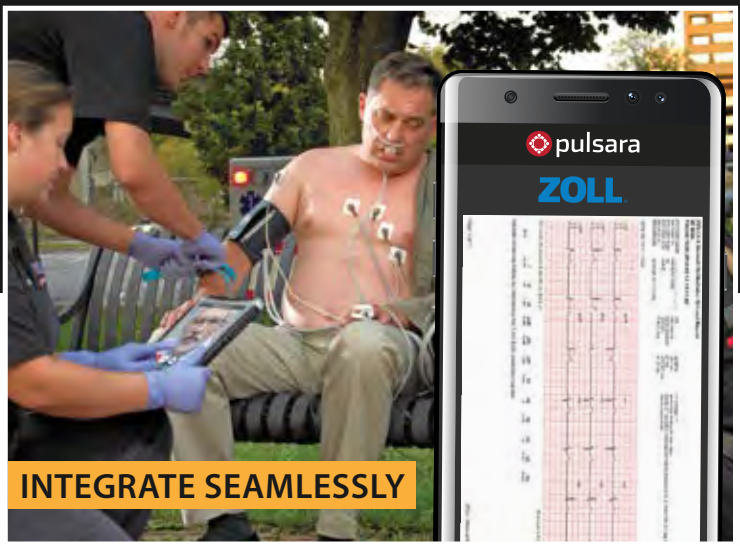

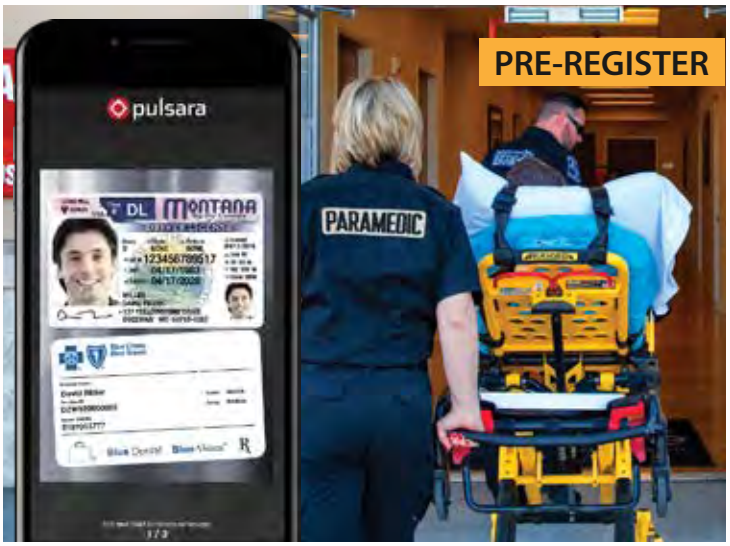

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EDITOR'S NOTE:

In the EMS Trend Report, we set out to identify the commonalities in how those who provide EMS services at all levels, and across all sizes and types of organizations, perceive industry trends, opportunities and challenges.

This fourth iteration of the EMS Trend Report continues the efforts of EMS1, Fitch & Associates and the National EMS Management Association to measure the pulse of the industry, and pave the way to future learning opportunities for shared success.

Nearly 3,000 individuals from a diverse representation of response areas and service models responded. Some of the findings identify perpetuated challenges that continue to require innovative solutions to address, while new questions offer unique insight to drive change. Others narrate growth achieved through collaboration.

Take the pulse of your agency's experience in relation to the findings in the EMS Trend Report to discover where you are thriving and where work is needed to advance the EMS experience. Start by sharing your feedback on the 2019 EMS Trend Report and the future of the profession with us at editor@ems1.com.

Jay Fitch, PhD, Fitch & Associates

Greg Friese, MS, NRP, EMS1.com

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EMS *providers and leaders share their perception of the state of EMS*

Field providers, managers, chiefs and medical directors share insights into the challenges and opportunities in EMS in the U.S.

By Roxanne Shanks, MBA, and Jay Fitch, PhD

This year began with reasons to feel hopeful about the future of EMS. In February, the Secretary of Health and Human Services announced a pilot program to reimburse ambulance providers for transport to alternative destinations and for treating but not transporting – a trial run of what would be the most significant change in decades in how Medicare pays for EMS care. While the details have yet to be revealed, the Emergency Triage, Treat and Transport model (ET3) has energized many in the profession who hope it is a significant step toward recognizing the true value paramedics and EMTs can bring to individuals and communities.

The announcement came on the heels of the release of EMS Agenda 2050, a vision for the future of EMS created by members of the profession. It describes a people-centered EMS system, one where clinicians and agencies are incentivized to do the right thing for the patient, take advantage of new technologies and other innovations, and focus on evidence-based interventions. Developed through a two-year, collaborative process, EMS Agenda 2050 is intended to unite our profession behind common goals.

As we see in these pages, our fourth annual EMS Trend Report, a wide range of opinions still proliferates through EMS, with some clear divisions on topics ranging from education, to what we should call ourselves.

The online survey was conducted in early 2019. Responses were received from nearly 3,000 individuals from a diverse representation of communities, system models and years of EMS experience.

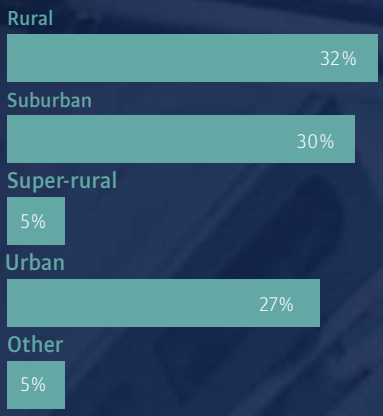
Survey questions were developed by Fitch & Associates in collaboration with the EMS1 Editorial Advisory Board and National EMS Management Association. A cross section of educators, EMS providers and EMS leaders vetted the questions prior to public release.

About the respondents

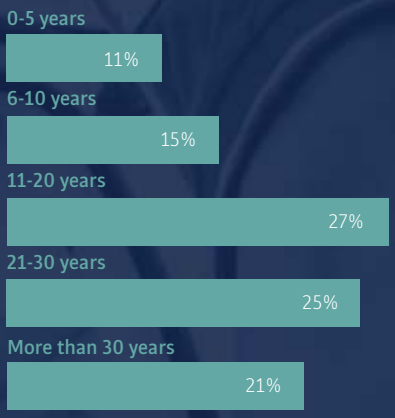
The Trend Report survey was completed by EMS professionals from all 50 states and the District of Columbia, as well as several in Canada and serving in the military overseas. They serve urban, suburban and rural communities in different service models and different roles.

SURVEY RESPONDENTS' DEMOGRAPHICS

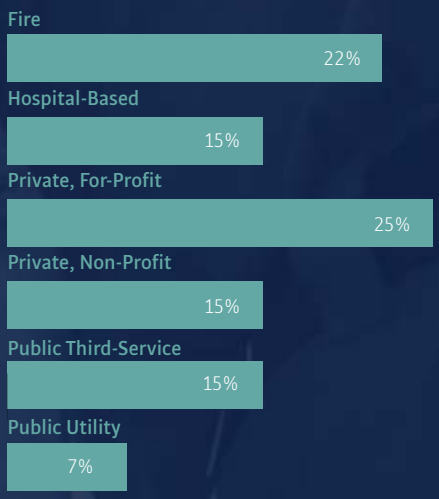
Primary response area



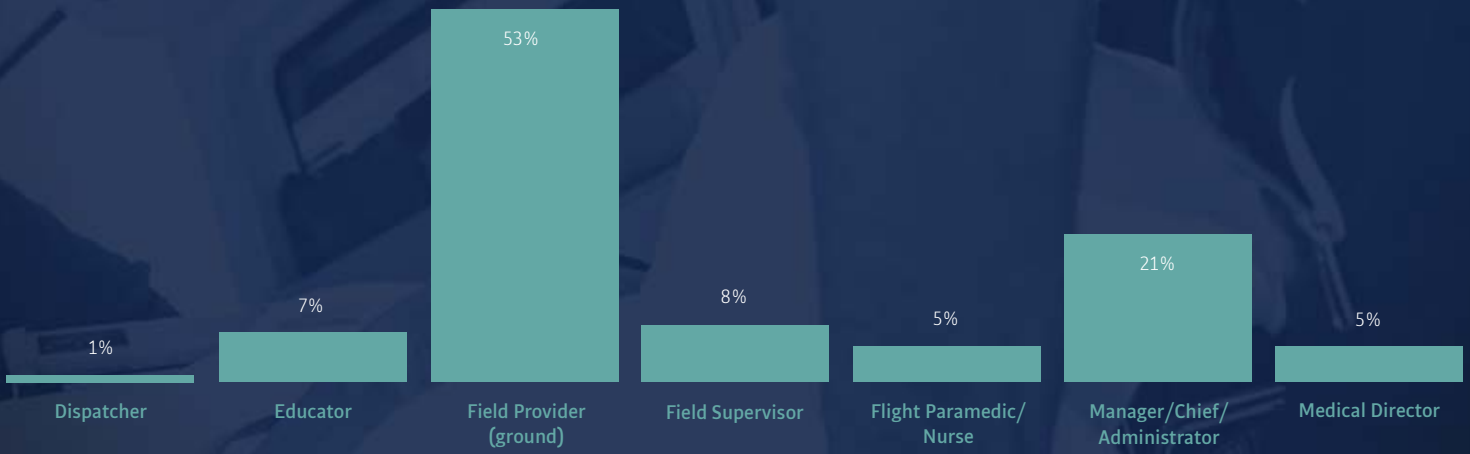
Years of EMS experience

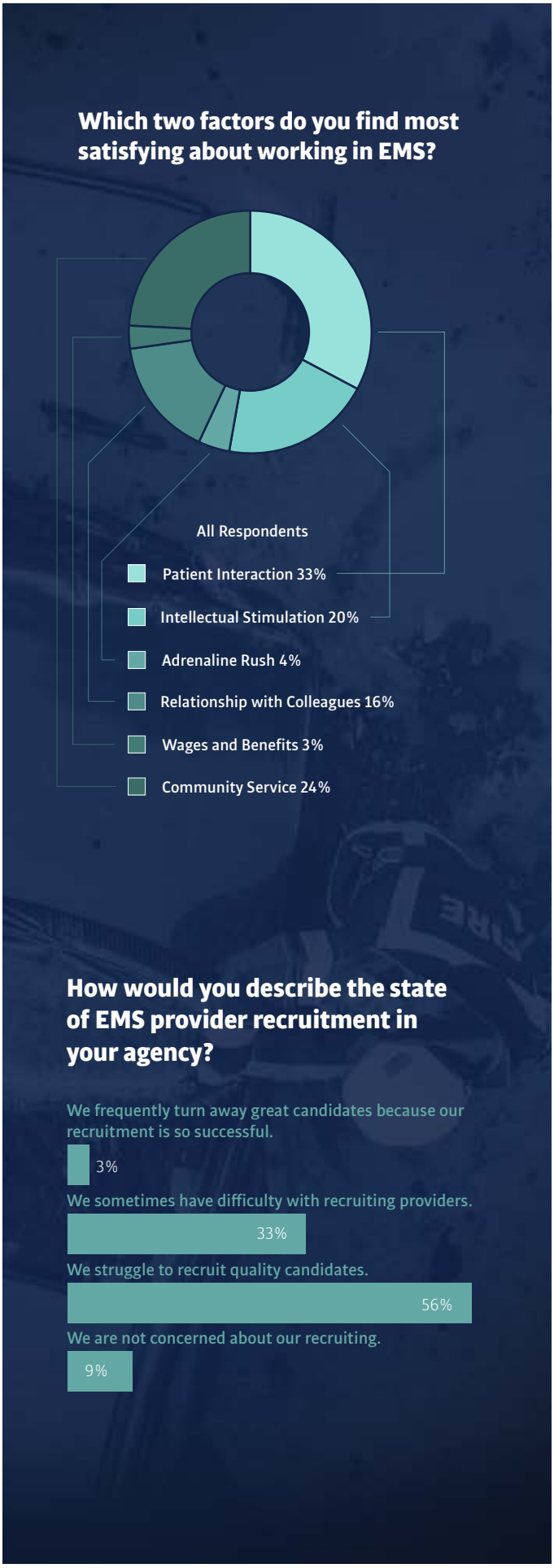


Service model



Job title





The EMS workforce

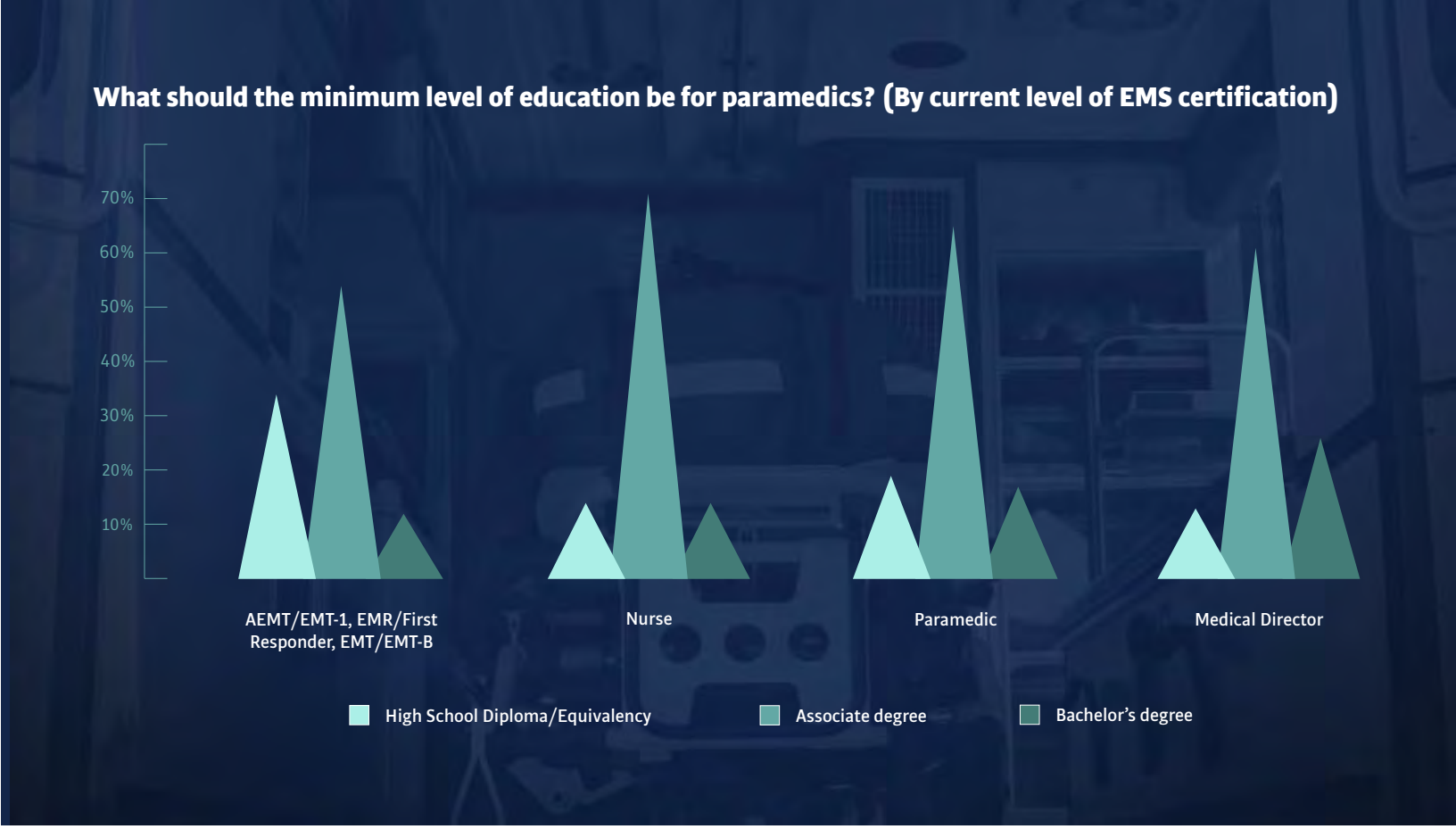
In last year's report, recruitment and retention stood out as the clear top concerns of EMS professionals, from field providers to chiefs. This year is no different, as the workforce continues to be the most critical issue for the profession according to survey respondents, followed by reimbursement and provider mental health.

For the first time, respondents were also asked why they thought people were leaving their agencies, as well as whether they planned on moving on from their current employer. Wages and benefits topped the list of reasons people were moving on to new opportunities, especially among for-profit ambulance services. Career advancement and career change also showed up prominently on the list.

One way to improve both recruitment and retention is to try to better understand what EMS clinicians are looking for and why they stay in the job. Recognizing that those answers might change over the course of a career could be key to recruiting the right people and keeping them in the profession. In this year's survey, we asked what factors respondents found most satisfying about working in EMS and found the answers varied depending on their levels of experience. While patient interaction and intellectual stimulation ranked at the top nearly across the board, the number of people who chose "adrenaline rush" was much higher in those in their first five years (11%) and five to 10 years (7%) than those with more experience.

More than a quarter of private, for-profit respondents planned to leave their current employer in the next zero to 12 months. Less than 10% of fire or public utility respondents planned to leave their employer in their first year.

Diving deeper into this issue will be critical for the profession. Are people who get into the job because of the adrenaline rush less likely to stay? Or are they just more likely to change their priorities as they're in the career longer? It's important to recognize how these factors could influence both recruitment and retention.



The medical director's perspective

This year's survey captured the thoughts of more than 130 EMS medical directors. As leaders of EMS organizations with a unique connection to both EMS and the healthcare system, medical directors will be key to the evolution of EMS and the paramedicine profession.

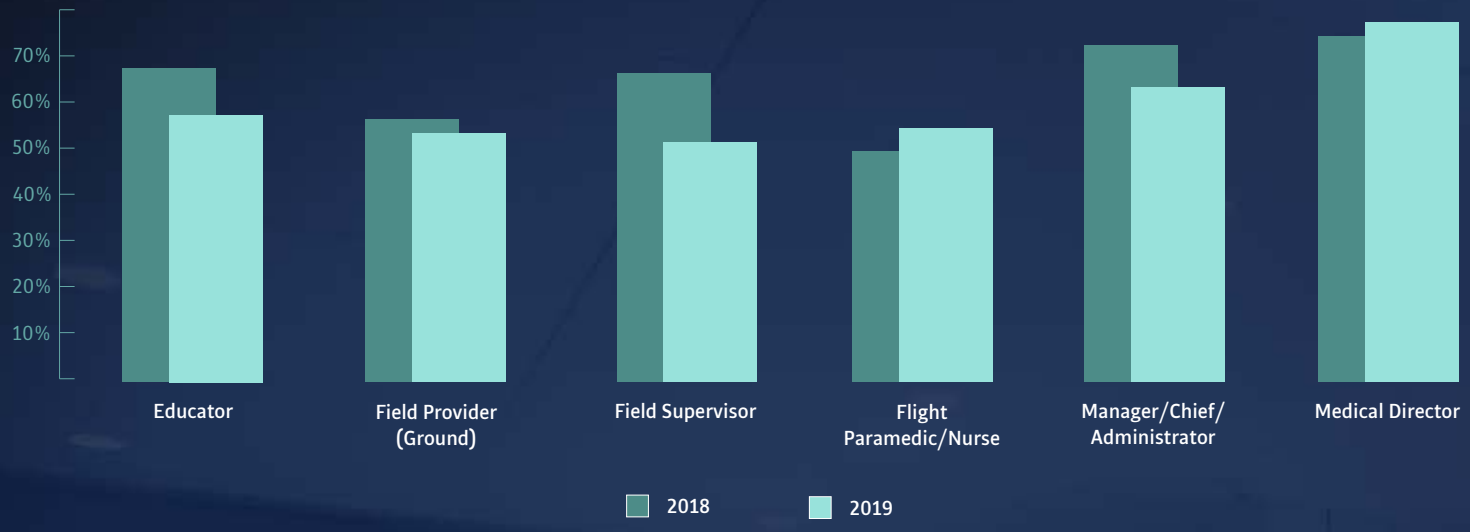
Unfortunately, the number of field providers who agreed with the statement that their medical director was "very engaged" with them remained this year at only 47%. Another sign that medical directors might not be as engaged in the overall operations and management of their organization: Nearly a quarter of medical directors were not sure if their organization's budget had increased or decreased over the previous year.

Medical directors' opinions on some of the more controversial topics in EMS today were similar to those of their colleagues throughout the ranks of EMS, but with some notable differences. Overall, only 15% of respondents feel a bachelor's degree should be required for paramedics; among physicians and medical directors, though, 24% want to see that as a requirement.

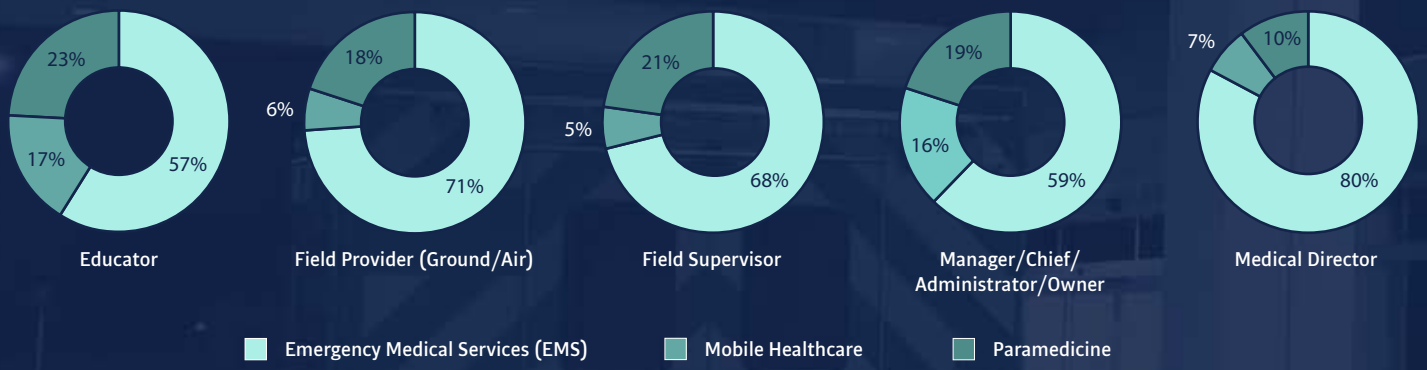
Medical directors also overwhelmingly support the term "emergency medical services" to describe the profession, rather than alternatives, such as mobile integrated healthcare or paramedicine. While the majority of survey respondents leaned in that direction, paramedicine earned higher support among field providers and managers than medical directors. These preferences could stem from many reasons, including the recent creation of an official EMS subspecialty of medicine. If proponents of the term paramedicine hope to create a professional identity for EMS clinicians, gaining the support of their physician colleagues will likely be an important step.

The medical directors surveyed are a hopeful group, though, and feel more enthusiastic about what's in store for EMS than any of their counterparts. Nearly 80% of the physicians who responded said they agreed with the statement, "I am optimistic about the future of EMS," while only 54% of field providers and 64% of managers and chiefs felt the same.

I am optimistic about the future of EMS. (Strongly Agree/Agree, by job title)



What term do you think should be used to describe the profession generally referred to today as "emergency medical services"? (By job title)



My organization has made the following a priority (Agree/Strongly Agree, by job title).

EMS agency preparedness

Despite the publicity around active shooter incidents, the seemingly ever-increasing threat of infectious disease and frequent major natural disasters, respondents continue to feel largely unprepared to respond to such catastrophic events. For example, 16% of respondents in 2018 and 2019 are "not at all prepared" for an active shooter incident.

Point-of-care testing, ECMO in the field, IV acetaminophen and impedance threshold device continue to have low adoption across respondents. Just 3% of respondents report nurse triage of 911 calls and 8% report telemedicine adoption, though we may expect these figures to change in the years ahead as ET3 emphasizes triage.

Provider health and safety

Across healthcare, provider burnout is receiving critical attention. Surveys of physicians have revealed high levels of burnout, with concerns that the declining mental and physical health of the workforce will lead to shortages of experienced clinicians down the road.

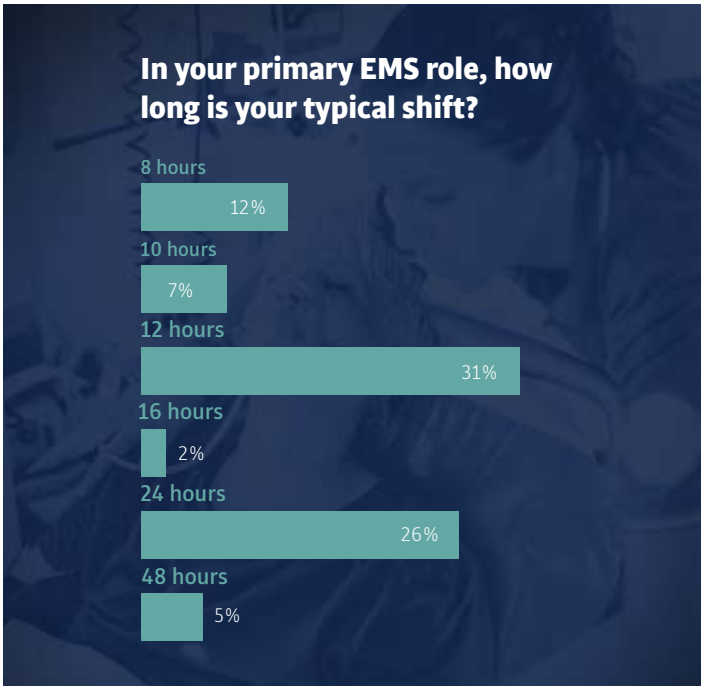
Overall, 12% of those surveyed reported high levels of burnout, with the highest numbers coming among field supervisors and respondents whose primary EMS role is with a private, non-profit service. Members of the fire service had the lowest levels, with more than a quarter saying they have no symptoms.

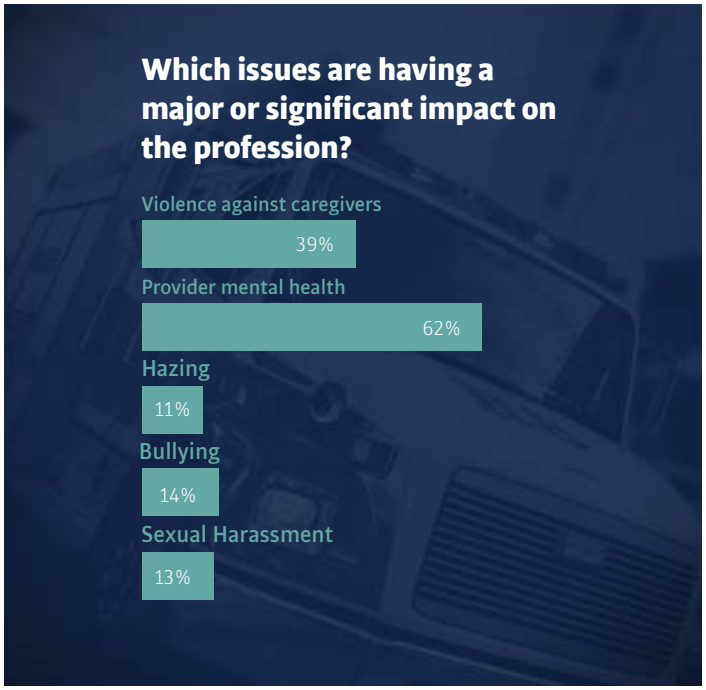
Despite relatively low numbers of self-reported burnout, provider mental health continues to be a concern of EMS professionals, with 62% stating it is having a significant or major impact on the profession. As in past years, there continues to be a disconnect between field providers and leadership as to whether they are addressing the problem. Among field providers, only 28% agree (a slight decrease from the 33% in 2018) that their service is making provider mental health a priority, compared to 59% of managers and chiefs, and 46% of medical directors. Members of public agencies (fire departments as well as third-service EMS departments) tended to think their organizations were tackling the issue more than those working for private companies.

As far as actual actions regarding patient and provider safety, perhaps nothing is more telling than whether we as a profession are addressing two known issues:

1. The use of lights and sirens
2. The impact of provider fatigue

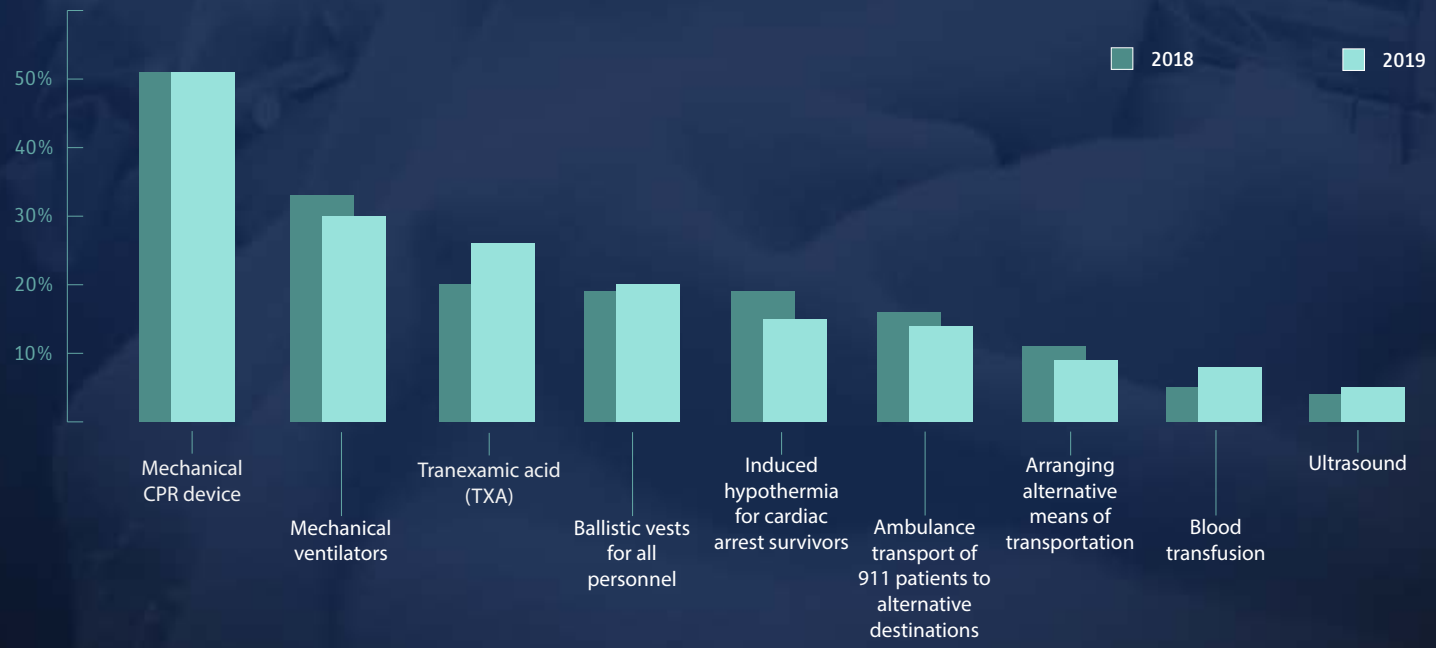
More and more research has indicated that not every 911 call requires a lights and sirens response, yet there is no sign that departments are changing their

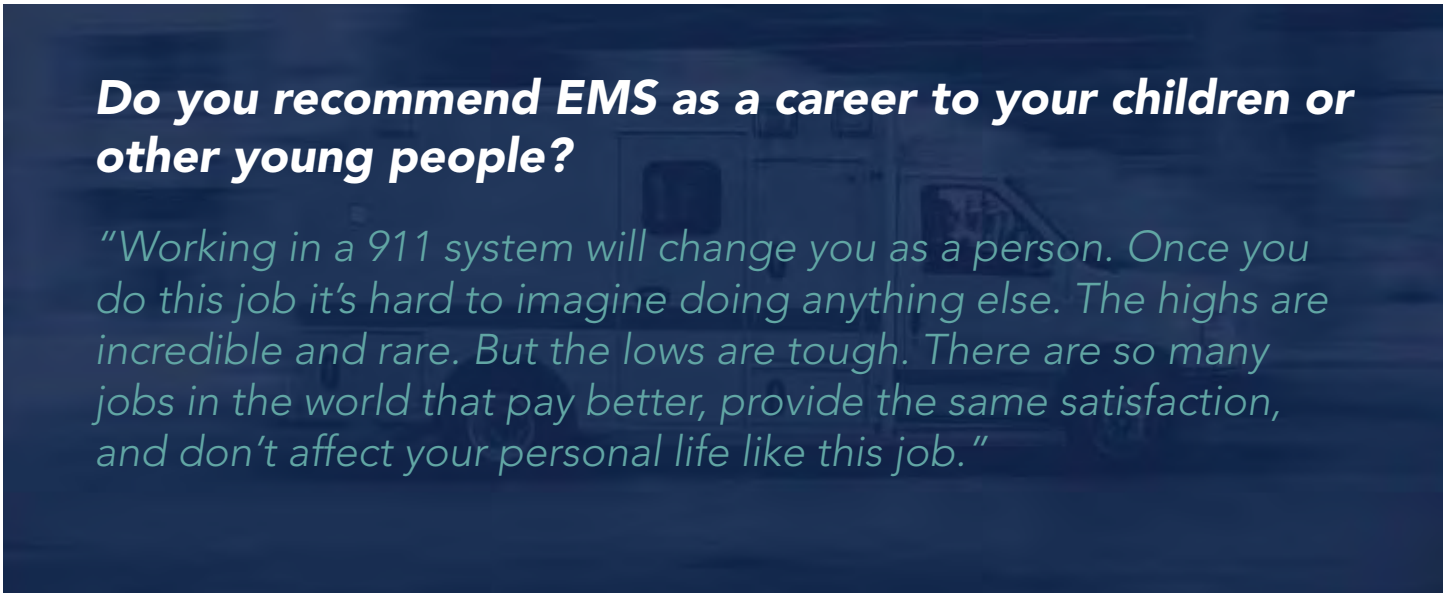




Did your organization's overall budget increase or decrease over the previous year's budget?

Adoption of procedures, treatments and technologies





policies on a wide scale. More than 20% continue to use lights and sirens on every call, with the fire service being the most likely to do so, and private, non-profit being the least likely.

Fatigue management also continues to be a struggle for many systems, and a source of disagreement between the field and the front office. More than half of field providers disagreed when asked if their organization was taking steps to address provider fatigue. Only 21% of chiefs and 27% of medical directors felt similarly. Sadly, even flight medics and nurses were skeptical, with 33% feeling no steps were being taken, despite the dangers of helicopter EMS.

Moving the profession forward

The last few years have seen little shift in the optimism of EMS professionals, with many remaining skeptical that the profession is headed in the right direction. Nearly 40% of respondents said they would not recommend EMS as a career to their children or other young people. This is a significant increase from 2018, when about one-third of respondents said they would not recommend EMS as a career to a young person. Reasons varied, with most providers citing:

- Low pay
- Physical and mental stress
- Lack of respect from the public and colleagues in public safety and healthcare

Could the next few years mark a turning point, though? Possible changes to reimbursement models, a renewed focus on provider health and wellness, and leaders pushing for increased professionalism all may have a positive impact on the profession. But to truly move EMS forward, we will also need to see better progress on issues that can be addressed by individual providers and leaders at the local level:

- Reducing the use of lights and sirens
- Making actual changes to improve patient and provider safety
- Increasing pay and benefits for clinicians

Until those basic improvements happen, it's hard to imagine why the people in the field serving our communities would be any more optimistic about the future of their profession. ■

About the authors

Roxanne Shanks, MBA, is a partner at Fitch & Associates. She serves as the CEO for LifeFlight Eagle Air Medical Program in Kansas City, Mo., and also as the executive director for the Association of Critical Care Transport. She has an extensive background in healthcare and EMS leadership with more than 26 years of experience in progressively responsible clinical and leadership roles.

Jay Fitch, PhD, is a founding partner of Fitch & Associates, and is internationally recognized for leadership as a consultant, educator and innovator in EMS and public safety.

Employee retention:

Engage EMS providers with opportunities for advancement

To retain personnel, EMS leaders must address factors beyond compensation, from work-life balance to training and support to take on new roles

By Jay Fitch, PhD

The 2019 EMS Trend Report confirmed that EMS professionals' deep concerns about recruitment and retention in last year's survey have not been alleviated. Once again, the ability to find and keep qualified people has survey respondents at all levels — from field providers, to medical directors to chiefs — worried. Not surprisingly, compensation is a common reason for leaving an EMS job. But it's not the only one.

Survey respondents also ranked career advancement opportunities as a significant contributing factor in why EMS practitioners leave not just their organizations, but sometimes the field entirely.

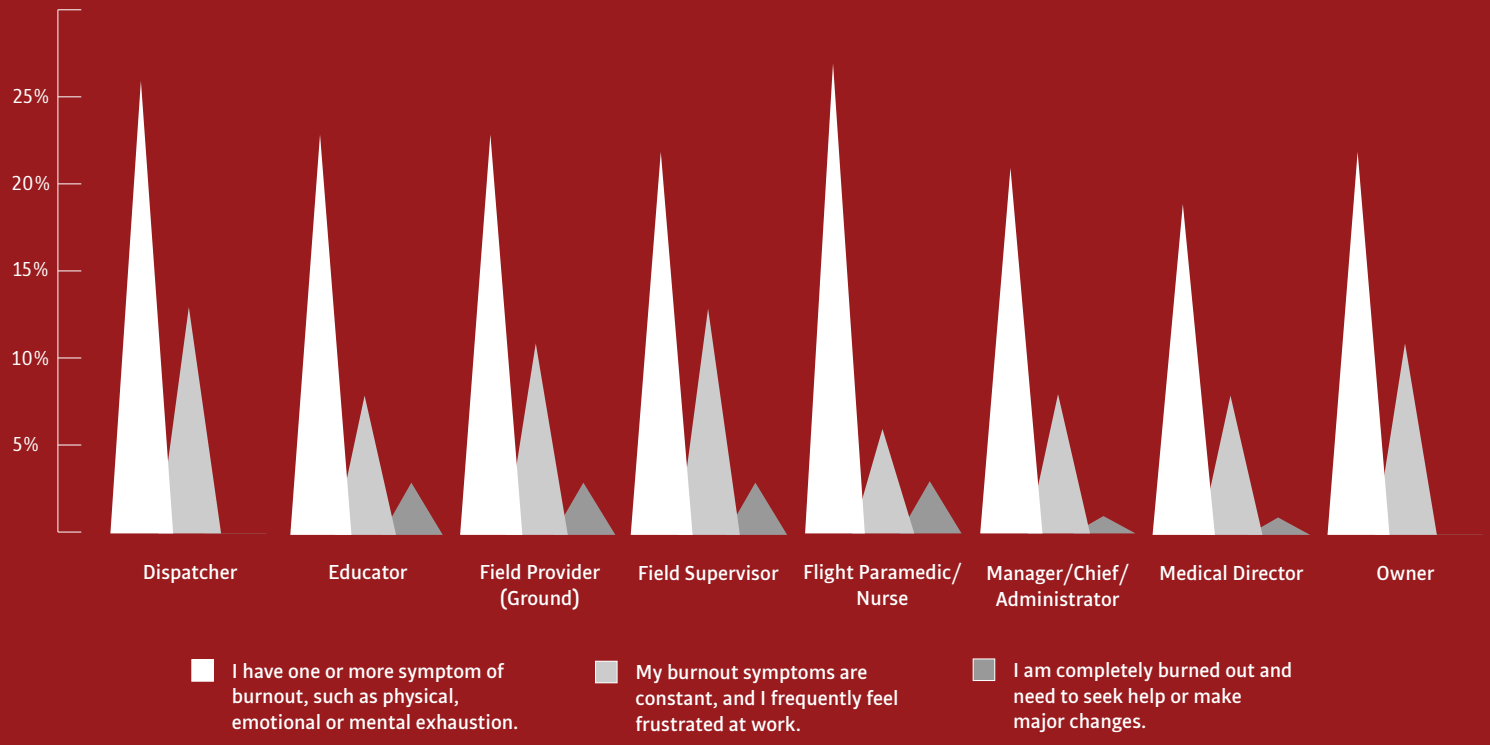
This year, we further probed retention by including a specific question about burnout, asking respondents, "Based on your own definition, how would you rate your level of burnout?" Field supervisors were the most likely to rate themselves with high levels of burnout: nearly 16% of supervisors said they experience constant burnout symptoms and frequently feel frustrated at work, or are completely burned out and need help or to make a change.

Over the years, in a number of the organizations we've worked with, supervisors have been described as Oreo cookies. That is, they see themselves as the cream filling (or glue) between crewmembers and upper management. When a difficult issue pulls those two factions apart, a little filling gets stuck on both sides of the cookie. Divided loyalties may be a factor in feeling frustrated and, eventually, burned out. Simply acknowledging the inherent challenges of the role — and recognizing the dual loyalties — is a first step toward decreasing burnout among mid-level managers.

What will improve field provider retention?

After the EMS Trend Report revealed retention as a top concern, a team of EMS professionals further explored incentives to help EMS organizations prevent losing EMS practitioners at the Spring 2019 Ambulance Service Manager program. The group constructed a targeted survey on this point. Their findings were consistent with the EMS Trend Report results as to the importance of wages and benefits. They also identified other opportunities to enhance retention, including better management of workload and career advancement opportunities. Across different age segments, respondents from

Based on your own definition, how would you rate your level of burnout?



Generation Z (ages 18-24) focused on workload, career advancement opportunities and flexible scheduling options; while Generation Y (ages 25 to 39), also known as Millennials, identified child care as a priority (possibly as a result of both parents working outside the home).

The ASM group also asked: "What change would you make to better EMS?" Beyond pay and benefits, frequent responses included:

- Improving work-life balance
- Recognition
- Increased education
- Participative management

Career advancement has been consistently identified in recent EMS Trend Reports as a significant factor in improving employee satisfaction. EMS leaders who care about retaining their best employees must address this issue and stop making excuses.

Even in small organizations where formal promotions are infrequent, agencies can find other ways to help EMS clinicians develop professionally and enrich their careers. Well-organized field training officer programs are an easy way to start. Depending on organization structure and system design, consider options such as designating station leaders, shift leaders or team leaders of specialty units (e.g., mobile integrated health, critical care transport, tactical EMS or search and rescue).

Find ways to support and reward those who take on other roles, such as training and education or interfacing with local public health and emergency management, and offer career advancement opportunities. Each of these are positions that could be established and might not necessarily require significant increases in compensation. The payoff, however, could be significant satisfaction, engagement and retention dividends for your organization. ■

About the author

Jay Fitch, PhD, is a founding partner of Fitch & Associates, and has spent more than four decades serving the EMS community as a leader, author, speaker, educator and consultant.

THE EMS EVOLUTION WE NEED

All levels of EMS stakeholders must bridge the gap between providers and administrators to overcome the hurdles facing the industry and to take advantage of the opportunities available

By Art Hsieh

Reading this year's EMS Trend Report, I'm struck by the fact that there's relatively little change in how we view ourselves and our industry from the previous year. That's to be expected of course – one year usually makes very little difference in opinion making. But that lack of change is but one sign of a looming disaster that we are facing in prehospital medicine.

Like the Titanic that lumbers through the night, heading toward its inevitable demise while its passengers slept unaware of what laid ahead, EMS is moving toward its destiny. At this moment, I'm not sure whether it will be evolution that propels us forward through the ice field of changing environmental conditions, or a head-on strike with a disaster that sinks us below the waves of change.

Breaking a destructive cycle

Each year's EMS Trend report provides a snapshot of what we want for ourselves. Field providers want – and need – increased pay, better benefits and safer working conditions. All professions want this, of course, but the need in EMS is becoming dire. Many, if not most, providers work more than one job in order to make ends meet. Sixty- to 80-hour work weeks are not uncommon. Fatigue is a known killer for EMS providers. Combine the mental and physical stressors related to this field, and we have a perfect recipe of a job that people love to hate, and leave after but a few short years.

This cycle continues even when we are witnessing a transformative moment in our industry. The data shows an increasing number of agencies providing community health services that positively effect patient and population outcomes. The federal government is making its first steps in creating the reimbursement process that will allow these innovative practices to take hold and thrive. But EMS providers, paramedics in particular, may be left out of this development.

Higher educated and trained health professionals, such as nurses, physician assistants and others working in allied health are poised to take over these new positions. According to the Trend Report, most EMS providers believe that the entry level to practice for paramedics is an associate degree. But certain segments of our industry are determined to make sure we don't get out of the ambulance driver's stereotype. While there are other voices that are advocating for entry-level degree paramedics, the path forward is anything but clear.

Meanwhile, financial reimbursements for existing services remain pitiful. Even tax-supported systems are feeling the strain of increased call volume

without increased support. While the value of EMS may be obvious to those within the industry, we've not yet clearly demonstrated that value to the public and those with the authority of allocating funds for services. Community paramedicine may shift that perception somewhat, but the paradigm won't change.

It boils down to what we believe the function of EMS is. The age-old debate of whether we are public safety or healthcare entities continues to be a drag on the industry. The time is coming to draw clear, unambiguous lines around what we do.

If it's public safety, then evidence supports a focus of performing time-dependent tasks really well. Training time would decrease, and retention of knowledge and skills would improve. If the paradigm is integrated healthcare, then specialist providers with deep knowledge and skill sets are needed.

Personally, I'm not sure which way we should go. The EMS Agenda 2050 seems to point to the latter. But, being a jack of all trades and master of none has been a head-banging exercise in futility. It's resulted in lackluster performance, inadequate reimbursement, poor compensation, and the recruitment and retention of a workforce that is poorly prepared to adapt.

Bridging the disconnect between field providers and EMS administration

The disconnect between EMS field providers and administration continues to be alarming. While no one level of administration is Pollyanna about the industry, it's clear that perceptions about what folks are doing to support the front-line EMS worker vary widely.

An agency's bottom line depends upon the EMS providers' ability to perform at a high, consistent level. The level of support must be targeted to meet their needs. A livable wage consistent with education, training and responsibility would be a start. A work schedule that allows workers to pursue a full life would begin the process of a stable work environment that promotes recruitment and retention.

photo: St. Charles County Ambulance District

Mental health is an issue we are just beginning to grasp in terms of its complexity and depth. It's far too easy to be dismissive of conditions that cannot be seen or felt. Typical employee assistance programs may not have the capacity to help EMS providers deal with the pain and heartache of the job. It's the rare agency that spends the time and money to develop programs that target the stressors intrinsic in the industry.

All of this seems obvious. Yet the results from the 2019 Trend Report reveal an unconscious bias among managers and physicians to shift operational challenges away from environmental factors and, in a sense, shift a sense of blame to front-line providers. In other words, the problem lies within the person and not the system. Without a paradigm shift, this situation will not likely improve any time soon – if ever.

Meaningful change to impact providers, agencies and communities

If I seem a bit jaded about what lies ahead, I am. On one hand, I see that EMS is evolving in a way that benefits all involved, from front-line providers, to organizations, to the community we serve. On the other hand, I see us as our worst enemy, unwilling or unable to change at any meaningful level.

While we squabble and deal with minutia, others are exploiting the opportunities that we may end up squandering away. Fixing this situation will take sacrifice from all levels of participants in EMS, from the CEO to the front-line provider. Will we be up to the challenge? ■

About the author

Art Hsieh, MA, NRP, teaches in Northern California at the Public Safety Training Center, Santa Rosa Junior College in the Emergency Medical Care Program. An EMS provider since 1982, Art has served as a line medic, supervisor and chief officer in the private, third service and fire-based EMS, and is a member of the EMS1 Editorial Advisory Board.

WHAT'S THE FUTURE OF EMS?

ASK MY MOM

Focus on how technology can enhance communication and patient care to predict the next paradigm shift of the industry

SPONSORED BY pulsara

By Kris Kaull, Pulsara

On a recent trip to Las Vegas, I wandered into Houdini's Magic Shop and watched as a performer razzle-dazzled each patron and then upsold them on a dream that they, too, could be part of the secret club of illusionists.

A few days later, my magic talent hit me … I have a (nearly) supernatural ability to see the future of EMS. In essence, you could call me a clairvoyant EMS psychic. My career has positioned me as an expert squarely at the intersection of EMS, technology and the human factor.

MY FUTURE PREDICTION

Looking into my crystal ball, I see a complete paradigm shift in EMS – one where the days of the traditional radio report and focus on transportation are a thing of the past.

In the near future, EMS will instantly and dynamically communicate in real time with different specialists to better meet the needs of the patient, playing an integral role in the greater healthcare ecosystem as we move to an out-of-hospital clinical model.

How do I know this? What's my secret?

I apply the "MAMA MOJO." I ask myself, "If my mom were a paramedic, what would she do?"

EXAMPLE No. 1: Mom uses the simplest, most frictionless way to communicate

Don't ask technology geeks their opinion, ask my mom.

How does Mom connect with her friends? Does she sit down at her desktop computer or open her laptop? Does she page her friend? Does she send a fax summary of the encounter? No. Does she use all of these technologies for a single conversation? Heck, no. Yet, when it comes to the critically ill or injured, we cobble archaic technologies together in hopes that it'll be OK.

On the flipside, Mom uses the simplest, most frictionless way to communicate – her smartphone or tablet. By being mobile-first, Mom can connect the way she wants to, with whomever she wants to, anytime she wants to.

In EMS, we need to adopt a mobile-first mindset. While rugged laptops and tablets have their place (for documentation of patient care after it is delivered) in today's world, documentation is not communication.

Yes, my mom can retroactively look up a text, video or Facebook post. However, the core value is her ability to connect in real time.

photo: St. Charles County Ambulance District

The challenge in today's healthcare world is to dynamically get the right information at the right time to the right people to make the best decision for the patient. While it may seem daunting to execute a coordinated and transparent communication system when so many players are involved, we actually do it all the time.

Consider Amazon: Each minute, more than 6,000 orders are processed without Jeff Bezos personally visiting each home to train the consumer. Instead, Amazon unites buyers, sellers, inventory, financial institutions and shipping companies to accomplish a very complex task – but they make it feel like a very simple transaction.

We need to do the same in EMS. The technologies that will flourish are those that work for the clinician and fit easily within their workflows.

If my mom needs instructions, then it probably won't work.

EXAMPLE No. 2: Mom cares more about communicating than about collecting data

Moving data from place to place is not the same as communication. Likewise, documentation is not the same as real-time communication. But what do we communicate? Data. They are related and closely connected, but not the same thing.

My mom cares very little about data. However, she does love communicating with people – and stores. In today's world, my mom can order a pizza from Domino's by texting a pizza emoji. Not only that, she can authorize her bank to pay for her order, and then, in real time, watch the pizza's journey to her door.

Shouldn't we have a similar plan in place when the outcome is much greater than food? Similar to ordering a pizza, everyone associated with the case could have instant, transparent and dynamic access to information.

The technology already exists. But our focus on only collecting data impedes us from using it to its full advantage. Data is important, but we need to communicate data in real time, not just collect it for future reference. Its strength is in what it can provide clinicians in the time-sensitive moment, and that requires real-time communication.

EXAMPLE No. 3: Mom doesn't love change, but she is motivated to learn new technology if it adds value

Expect tradition to be the greatest challenge. Like most people, my mom doesn't love change. She doesn't seek the latest and greatest gadget. She's not interested in being cutting edge.

But she is motivated to learn new technology if it adds value. Being able to connect with her grandkids via video adds value. At 67 years old, my mom connects via FaceTime to her youngest, 3-year-old grandson every morning. Then, a few times a week, she connects via FaceTime with her oldest, 17-year-old granddaughter who's at college. Seeing their faces while maintaining connection made learning new technology worthwhile.

In EMS, we need to take the best practices from other industries and apply them to our world. In the future, telehealth will be the norm. Gone are the days of stationary, expensive workstations. If my little nephew knows how to video call his Grandma, then our medics should be able to video chat with other clinicians in real time using the same simple device.

What is the value for EMS? It's an opportunity to be part of the greater healthcare team. By utilizing a mobile-first communications platform, the EMS clinician is now empowered to build a patient channel and connect with other care providers seamlessly. The result: streamlined communication and workflows, improved operational efficiencies, tangible cost savings, significant reduction in treatment times and better patient outcomes. It's about people.

THE FUTURE, UNVEILED

As EMS transitions from a transport model to an out-of-hospital treatment model, many things will change – educational standards, reimbursement models and the way we communicate. The change is coming. If you're interested in catching an early glimpse of our EMS future, consider becoming Facebook friends with Mama Kaull. ■

About the Author

Kris Kaull, BS, NRP, FP-C, has driven innovation and positive change in EMS for over 26 years. Kris is a national speaker, writer and entrepreneur. In 1999, he started Paramedic.com and then in 2007 co-founded EMS1.com, the leading EMS website. Currently, Kris is the chief marketing officer for Pulsara, an evidence-based, mobile health startup. He has worked as a firefighter captain, paramedic and ambulance service director and continues his practice as a critical care flight paramedic.

Roundtable:

EMS leaders react to the 2019 EMS Trend Report

Our EMS expert panel identifies actions EMS leaders can take to improve provider engagement, satisfaction and performance

The fourth annual EMS Trend Report explores how recurring and emerging trends are shifting in prehospital medicine.

We asked industry experts to review and react to the survey results, how they reflect current healthcare trends, and how to make the data actionable for EMS leaders.

The panel includes:

- **Brooke Burton**, NRP, FACPE, quality director
- **Chris Cebollero**, EMS consultant
- **Maia Dorsett**, MD, PhD, EMS physician
- **Brian LaCroix**, FACPE, NRP, president, NEMSMA
- **James MacNeal**, DO, MPH, FACEP, FAEMS, NRP, medical director
- **Matt Zavadsky**, MS-HSA, EMT, president, NAEMT

EMS1: Which finding surprised you the most?

Brooke Burton: After the 2018 survey, I commented on my surprise regarding so many agencies still using lights and sirens for every call, and I am surprised there was not more of a change this year. Very few patient conditions necessitate the increased risk involved in saving a few seconds of time. Our industry needs to focus on evidence-based practices. Plenty of evidence exists proving the practice of red lights and sirens saves little time overall and significantly decreases the safety of the field provider, patients and other members of the communities we serve. If our overall mission is improving the health and safety of our patients and communities, we should be engaging in practices which decrease their risk of death or injury. Industry leaders should be working to change the hero culture behind these types of outdated policies, educate ourselves and the public about safer practices, and implement change based on evidence and best practices.

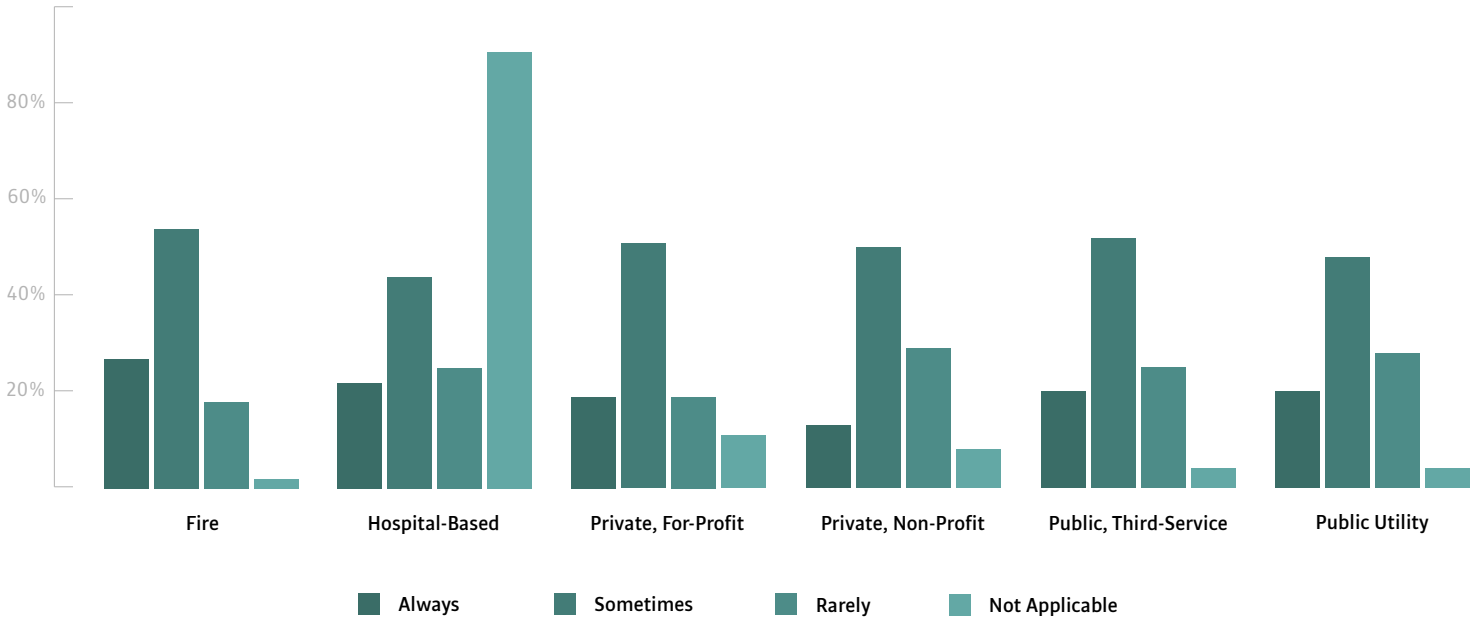
I was surprised by the number of managers and chiefs who were not optimistic about the future of EMS. If the leaders of the industry are not optimistic and motivated, how can we hope for the people we lead to feel optimistic? Leadership sets the tone and example for the entire organization. Continuing leadership education is as critical as medical education for the field. Leaders need to acquire resources to remain optimistic, face challenges and provide solutions to our toughest industry problems. Leadership education and networking provide those resources.

Matt Zavadsky: The value of EMS service delivery is something the industry has to address as we look toward future economic sustainability, and the ability to attract and retain professionals we rely on to serve our communities. The data in this report reveals that across all delivery models, an equal percentage of agencies experienced a budget decrease, or no change in their budget from the previous year; 36%.

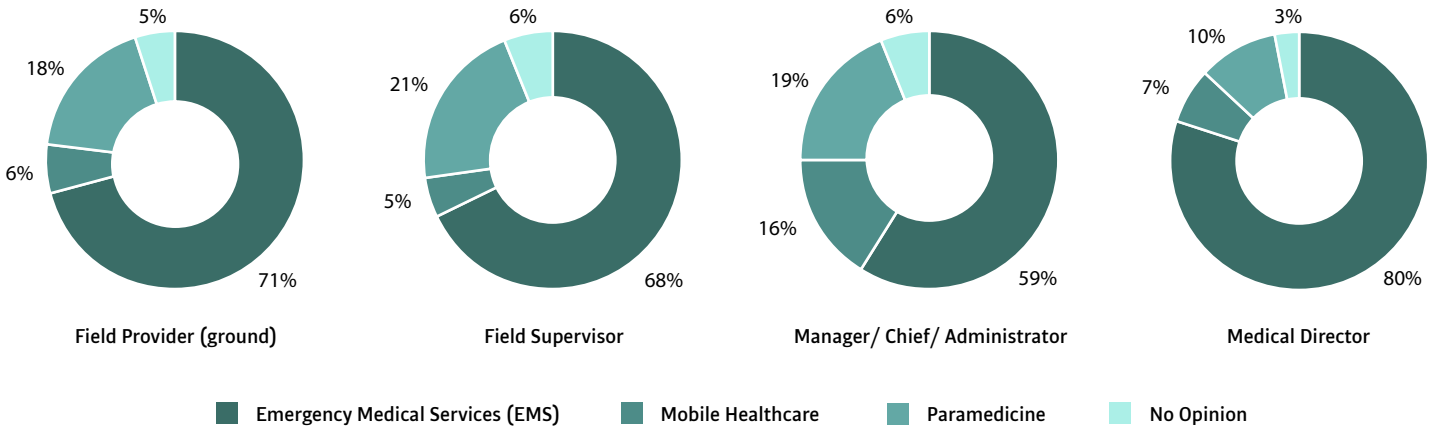
Delivery costs are likely not decreasing, but this data may suggest that the payers of EMS services (taxpayers, commercial insurers and others) are tightening the reins on the funding for EMS delivery. This may be an indication that EMS agencies need to continually seek ways to implement new economic models based on a new value proposition for those paying for our services.

Provider and community safety must be a primary goal of EMS agencies. Running hot presents the highest risk to our providers and our community. Yet, 70% of the respondents report that they run hot to all

Do you respond to 911 calls using lights and sirens?



What term do you think should be used to describe the profession generally referred to today as "emergency medical services"?



(20.3%) or most (50.2%) 911 calls. This is despite the fact that virtually every study that has looked at the effect of response times on patient outcomes have found no correlation to any response time greater than 5 minutes on patient outcomes.

NHTSA and Dr. Doug Kupas released a report on the use of hot responses, including a meta-analysis of more than 202 studies and reports on the issue to prove this case; including a study that revealed patients have actually not called 911 because of their concern about the spectacle it creates. If we are serious about provider and community safety, and ensuring the public calls 911 appropriately, we need to seriously address the glaringly inappropriate way we respond to medical calls in our community.

Brian LaCroix: One of the things that surprised me was the medical director's reluctance to embrace the term paramedicine. I do agree it may have something to do with their own hard-won efforts to establish a sub-specialty which they have titled EMS. That said, the reference to the career-field is less important to me than the title of the providers themselves.

I'm hopeful medical directors could be persuaded to support referring to all providers as paramedics rather than the dizzying array of labels we use today. The National EMS Advisory Council identified no less than 37 different names being used across the country to identify people who work in an ambulance. We have created confusion about our vocation rather than demonstrating professionalism and unity. This is not helping our cause with legislators/regulators, the media and general public or insurance payers.

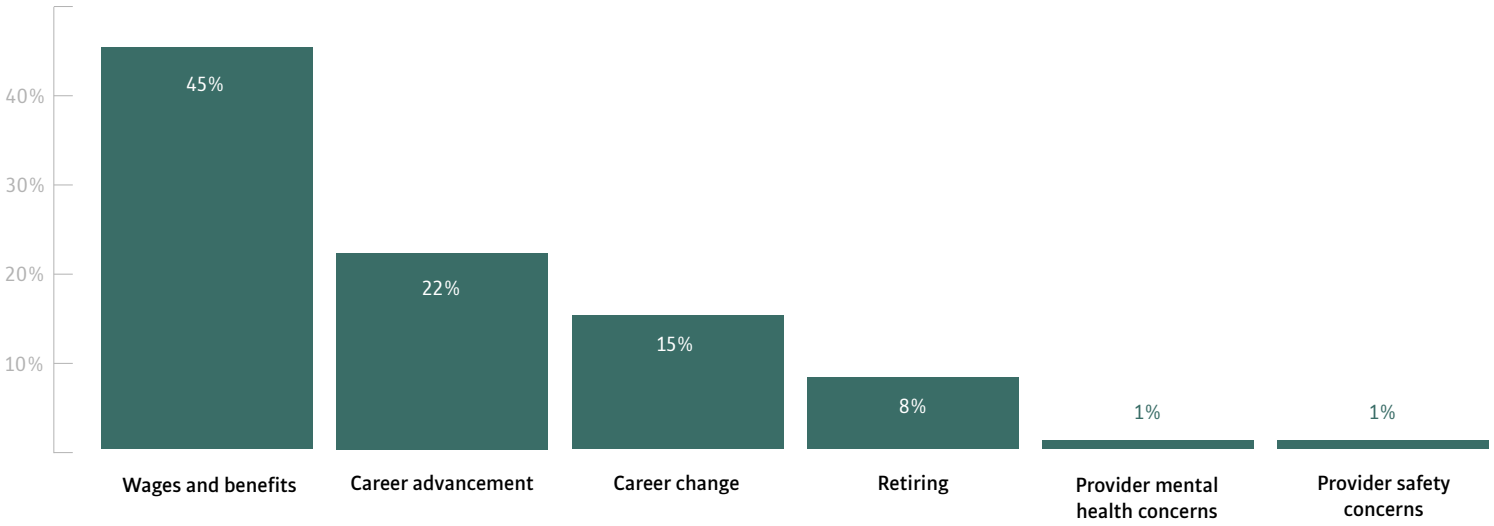
As more physician leaders come to appreciate the value of a common language with our stakeholder groups, more of them will potentially change their views on this issue. Consequently, it will be important to cultivate and educate physician champions to help move the nomenclature conversation forward.

Maia Dorsett: One lack of change to focus on (not that I find it surprising) is the degree of medical director engagement, where less than half of providers felt that their medical director was "very engaged" with them. While I would disagree that medical director engagement is measured by their knowledge of the budget (medical director engagement should predominantly focus on the quality of clinical care and the education and wellness of the people providing that care), it is an important growth area for EMS if we are to improve quality of care provided and integration with healthcare overall.

James MacNeal: I am most surprised by the disparity between EMS providers and medical directors regarding the outlook for EMS. I would encourage EMS providers to have regular interaction with their medical directors to continue to engage in discussions about working together to move EMS forward locally. We can't all sit idly by waiting for a magical federal agency to come fix the woes of prehospital medicine. It is going to be a local issue, and we need to work to find solutions within our own states to move us forward.

Chris Cebollero: We have known for many years now that our workforce is our main concern when dealing

What is the most common reason providers are leaving your agency?



with recruitment and retention. It is surprising that in this, the fourth year of this study, we as a career field are still seeing the numbers concerning our workforce and making EMS a career rather than a steppingstone. We need to focus more attention on creating the workforce that will be engaged – when they are engaged, they are satisfied, when they are satisfied, they are productive, when they are productive, they deliver great patient care.

I did think it was important that this survey asked why individuals are leaving EMS agencies. We need to focus in on the why and develop a blueprint to keep our people. We know that until we fix the reimbursement issue, we won't be able to fix wages, but, developing a highly engaged workforce can happen, and that should be the first step.

How do the findings of this year align with other trends in EMS and healthcare?

Brooke Burton: Reimbursement models in healthcare overall have been changing and must continue to change in order to be sustainable, and EMS is no exception. ET3 is a good start, but more must be done to improve reimbursement so ambulance services can afford to increase field provider compensation. Reimbursement is the start of a domino effect which touches every aspect of a service. Better reimbursement leads to improved provider compensation. Better compensation allows providers to work less hours overall, which reduces fatigue, provides better work/life balance, and improves home life and overall resiliency. More resilient providers call out less and have less overall turnover, which decreases costs to services and allows services to reallocate funds to improve equipment and patient care. Our industry must come together to advocate for sustainable reimbursement to build the foundation which will ultimately improve many of the pressing problems we face today.

Matt Zavadsky: The expanding role of EMS within the healthcare system likely provides the greatest opportunity for us to meet the IHI Triple Aim and demonstrate additional value to our stakeholders. Respondents to the Trend Report seem to agree with the transformation of EMS into services beyond simply 911 response and transport to an ED. Sixty-one percent of field providers, 64% of medical directors and 70% of owners agreed or strongly agreed that MIH is the future of EMS. Similarly, 72% of chiefs and 79% of medical directors who responded to the survey indicated their agency is either considering, planning or doing an MIH delivery model. This is an important sign for our profession.

Brian LaCroix: This year's survey paints a picture of a workforce feeling weary, disconnected from mission and leadership, underappreciated and unwilling to recommend the career-field to others. At the same time, leaders and medical directors seem to r eport a relatively optimistic view of their work and the future.

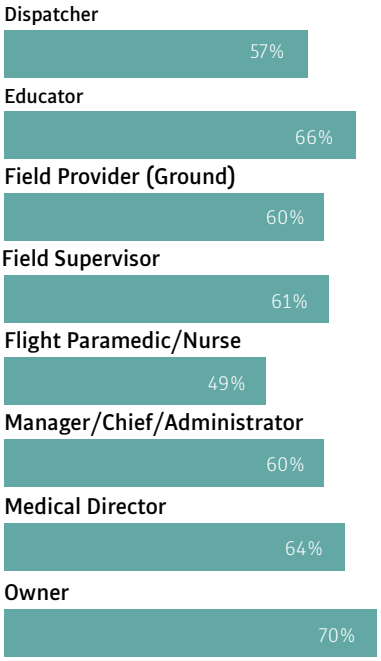
It would be easy to feel discouraged by this data and some of that reaction may be warranted. In the context of our world today, it feels somewhat understandable. We live in a highly polarized political environment, including mistrust of law enforcement

and other uniformed disciplines, with a generally tumultuous environment in our society today.

Like with so many challenges of leadership, I encourage that we focus on the long view. With a realistic and sober assessment of our problems, a genuine commitment to find solutions and a healthy dose kindness toward one another, we can work through difficult problems over time.

Maia Dorsett: The depersonalization of patients and the burnout/moral injury of the frontline clinicians, summed up by the following survey response: "[It] breaks you and turns you into a heartless person" (field provider, 11-20 years). Patient interaction was one of the most cited reasons for finding EMS satisfying, but 12% of respondents had high levels of burnout and this parallels other areas of healthcare as well. People enter this profession with the noble goal of caring for others. It is easy to become discouraged by a system that can make it difficult to do so and does not always take care of its own. I do feel optimistic though – the more we recognize this as an issue, the more we can come up with viable solutions to address it.

Mobile Integrated healthcare/community paramedicine is the future of EMS. *(Strongly agree/Agree)*



James MacNeal: The reimbursement trends are consistent. The new proposed payment model is interesting, but we will need to be cautiously optimistic to see if it actually pans out.

Chris Cebollero: I think we are still being stagnant with what we are finding in each year's Trend Report. A large amount of work goes into surveys like this one, yet to me, EMS leadership is just looking at the numbers and not trying to fix the underlying causes behind the numbers. This has to be a focus of using this data to make the changes we want to see. I found it interesting that EMS medical directors focused on how paramedics should have bachelor's degrees and keeping the name EMS over any other name. I was disappointed to see a 12% burnout rate. In the days of increased first responder suicide, we have to be able to address the subject to avoid further behaviors that lead to providers ending their lives.

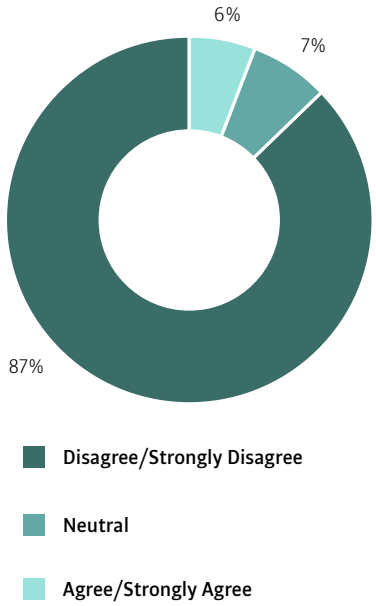
What action or actions do you recommend to EMS leaders based on the findings of the report?

Brooke Burton: Fatigue mitigation needs to amount to more than a recommendation to drink more caffeine. Our industry can do better in developing industry-wide fatigue policies modeled from the trucking and airline industries. Patient care and provider wellbeing both improve when providers are well rested and focused on daily tasks.

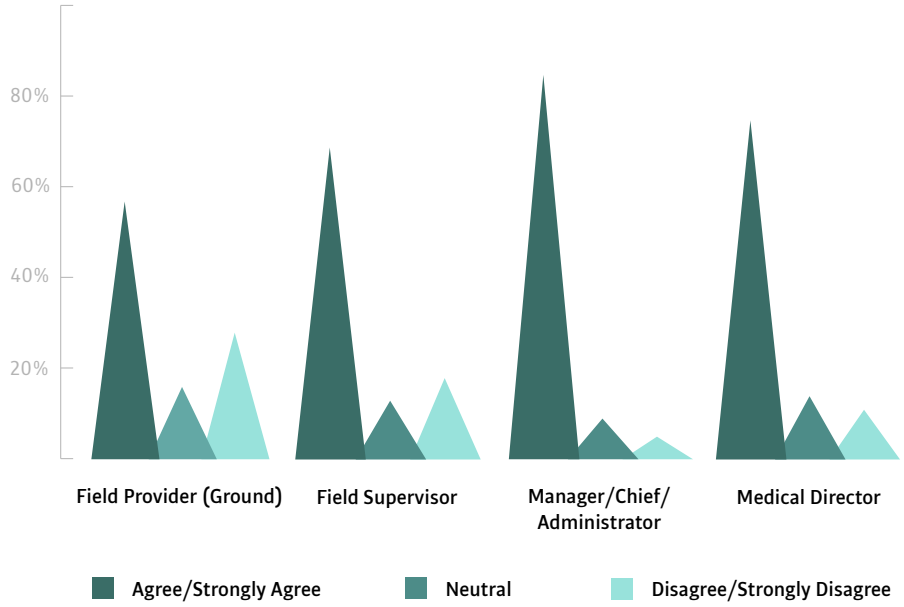
With short attention spans, field providers need to see their leaders taking action. Changes in EMS take too long. Leaders working on problems of resilience, fatigue and retention who take several years to come up with plans of action are fueling the disconnect with the field, who need to see faster results to feel the problems are being addressed. Leadership is service, and leaders exist to serve the field providers. Give providers a say in the efforts your agency is undertaking. Remove silos and have groups encompassing all departments come together to champion these causes of resilience and provider wellbeing. Empower your groups to make change. We should be constantly evaluating our practices and making small, fast changes to optimize every aspect of our services. Doing things the way they have always been done is outdated thinking. We should have the bravery to try something new, adopt the changes that work and adapt our outdated practices.

Matt Zavadsky: Eighty-three percent of all respondents to the Trend Report indicated that the current reimbursement for EMS does not cover the cost of service provision. And, 87% disagreed with

The general public understands what EMS professionals do.



My organization has made EMS provider safety a priority.



the statement that the public understands what EMS providers do. One is directly tied to the other. We have lots of work to do in order to explain and demonstrate to our communities what EMS actually does and the value we bring to patients and payers of our services.

Failure to do so will make it very difficult to maintain financial sustainability in the future. EMS leaders, national associations and field providers should work together to better educate everyone on the role of EMS and the crucial role we play in our nation's healthcare safety net.

Brian LaCroix: Two things; Create a mission-driven organization and promote a culture of safety.

The fact that nearly 40% of survey respondents would not recommend this career to family or friends is alarming. Leaders really need to tackle this head-on, examining the cited reasons of pay, lack of respect, etc. However, I believe there is a much more fundamental issue here, especially given that those in fire and third service agencies claim to have less of an issue here. But this is not about the historically self-destructive narrative of fire vs. private, I believe this is about mission – being part of something bigger than ourselves.

Very generally speaking, institutions like the fire service, the military and others have deeply established their purpose – their mission. Working at a focused mission-driven agency provides exceptional intrinsic value that can supersede all sorts of issues regardless of a service's tax status.

Secondly, a passionate and transparent effort to advance organizational safety is a critical success factor. When just 28% of field providers express confidence that their bosses take these issues seriously, it's time for leaders to sit up and take notice. Time and resources spent on improving patient safety and provider mental health, and addressing violence, burnout and more can have a profound impact on eliminating patient harm, improving retention and building a great place to work.

Maia Dorsett: The most notable theme is the disconnect between leadership and frontline provider. Throughout the report, in terms of addressing workforce retention, provider safety and fatigue, frontline EMS providers did not feel that their organization was doing as much as leadership did. I think this is a prime example of translation from the top – as leadership, we sometimes sit in a room, plan something and implement it without getting the input, buy-in and feedback from those on the ground. Change does not just happen from the top, but rather with the input and drive of the entire organization.

My organization is taking steps to address provider fatigue.

In terms of issues like wellness and mental health (just like patient care), we need to make sure to actively engage everyone so that the initiatives we develop are both meaningful and actionable. We need to find ways to nurture the inherently noble reasons that people chose this profession and make them feel valued within the system.

James MacNeal: I'm also surprised about the continued push to change the name. What we do in the field is not paramedicine – it is medicine in a different environment. I expect my first responders, EMTs and paramedics to take care of patients in their care exactly as I would in the same environment of care.

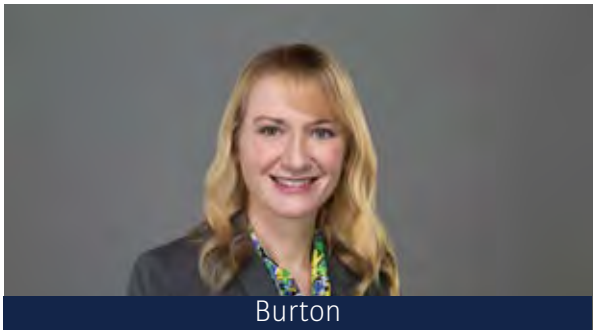
I am tired of the old adage, "EMS doesn't diagnose." It is time to step up to the plate and realize, that as a first responder, EMT and paramedic, you are the most critical piece of the healthcare system for the sickest of the sick. We also need to continue to work to show our quality and how we as EMS providers make a difference in the outcomes of our patients.

That shiny new cath lab and Level I trauma center do the patient no good for entire prehospital phase of care. The outcomes of these patients are greatly influenced by the EMS providers that care for them during the first and most critical time of their emergency. That is the universal message we as a specialty need to continue to convey to our administrations, legislators and governors. Changing our name at this point will only confuse the public more. The energy spent on a name change should be focused on proving our outcomes and continuing to influence the public who already knows our name.

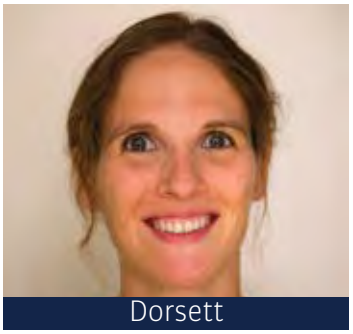
Chris Cebollero: Leaders can start making a difference with their workforce and develop that engagement by using this document as a blueprint to develop the future success of their service. Take this document, get members of the workforce, supervisors, managers, etc., and break this survey down and brainstorm on how to make a difference in your service. Develop a new vision, build a campaign around that vision, and make it your agency's commitment to push change in next year's survey. Collectively, we can make a difference, and leaders are always looking for the best ways to change and set a new direction. This Trend Report is your directional map to how to begin that journey. ■

About the panel


LaCroix


Burton


MacNeal


Dorsett


Zavadsky


Cebollero

Brooke Burton, NRP, FACPE, is the division chief of quality and training for Falck in Alameda County, California. She is a board member of the National EMS Management Association (NEMSMA), where she is the board liaison to the Quality Committee and is the Executive Board secretary. She serves as a trustee on the Board of the National EMS Quality Alliance, where she directs the Communications Committee, serves on the Measurement Development Committee, and is a member of the ET3 project Technical Expert Panel.

Matt Zavadsky, MS-HSA, EMT, is the chief strategic integration officer for MedStar Mobile Healthcare in Fort Worth, Texas. He is also the president of the National Association of EMTs and chairs their Mobile Integrated Healthcare and EMS Data committees, and is the co-author of the book "Mobile Integrated Healthcare – Approach to Implementation."

Maia Dorsett, M.D., Ph.D., is a physician at the University of Rochester in upstate New York and is board certified in both Emergency Medicine and EMS. She is the medical director of Gates Ambulance and EMS Education Programs at Monroe Community College. She is also the president-elect of the New York Chapter and chair of the Education Committee for the National Association of EMS Physicians.

Brian LaCroix, FACPE, NRP, is the current president of the National EMS Management Association and serves as the liaison to the Paramedic Chiefs of Canada. He is immediate past-chair of the Hennepin County (Minneapolis) EMS Council, chair of the Century College EMS Advisory Board and Allina Health's Heart Safe Communities Steering Committee, and committee chair on the Regina Hospital Foundation. He recently retired as president and EMS chief of Allina Health Emergency Medical Services, St. Paul, Minnesota, and is a fellow in the American College of Paramedic Executives.

James MacNeal, DO, MPH, FACEP, FAEMS, NRP, began his career in emergency medicine as a paramedic. He holds an American Board of Emergency Medicine/Emergency Medical Services certification and completed an EMS fellowship at Yale University. He is EMS medical director of Mercyhealth.

Chris Cebollero is a nationally recognized emergency medical services leader, best-selling author and advocate. Chris is a member of the Forbes Coaching Council and available for speaking, coaching and mentoring. Currently, Chris is the President/CEO for Cebollero & Associates, a medical consulting firm, assisting organizations in meeting the challenges of tomorrow.

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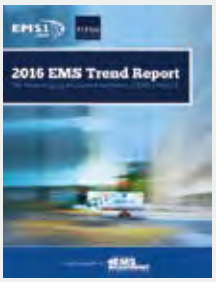
EMS TREND REPORTS

2018 EMS Trend Report

2017 EMS Trend Report

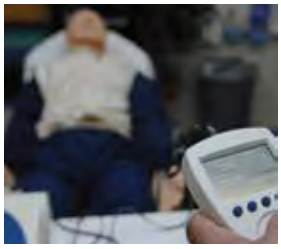


2016 EMS Trend Report

MORE FROM FITCH & ASSOCIATES

Engaged supervisors set the tone for employee retention

It is the direct supervisor who has the most control over the everyday culture, work environment and conditions for his or her employees.



5 keys to implementing new technology in EMS

Solving a clear challenge, identifying champions and following these implementation steps will make change easier.

4 steps to improving EMS retention with onboarding

Overhaul the onboarding process by investing in these areas to increase the success and retention rates of new employees.

Patient-centered EMS leadership

Achieve this healthcare quality improvement aim by shaping EMS culture to match strategic objectives.

MORE FROM EMS1

Roundtable: Engaging EMS providers to improve morale

Identifying providers' needs and implementing outside industry strategies can create an EMS culture that fosters retention and growth.

Implementing change without breeding discontent

It is possible to make meaningful improvement that also results in happier employees and a healthier bottom line. Learn the recipe for success.

Defying the EMS retention crisis: Why are great people leaving EMS?

Stop the talent bleed by understanding and overcoming the sticking points that drive EMTs and paramedics out of the field.

MORE RESOURCES

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