

The Governor's EMS Readiness Task Force

FINAL REPORT

February 15, 2007

Task Force Membership

Chairman

Greg Reid
Director, REACT EMS
Shawnee

Pat Mundy
Director, Crescent Ambulance
Crescent

Co-Chairman

Jimmy Johnson
President, Life EMS Inc.
Enid

Scott Randall
Director, Creek Nation EMS
Okemah

Governor's Liaison

Jay Mitchell
Regional EMS Administrator,
Oklahoma State Department of Health
Oklahoma City

Gina Riggs
EMS Coordinator, Kiamichi Technology
Centers
Poteau

Joe Barrett
Director, Bryan County EMS
Calera

Ray Simpson
Director, Parkview Ambulance
El Reno

Brian Burrell
Program Director, Tulsa LifeFlight
Tulsa

Ann Singer
Senior Vice President, EMSA
Tulsa/Oklahoma City

Ron Feller
Area Manager, Air Evac LifeTeam
Moore

Rebecca Smith
Compliance Officer, Muskogee County
EMS
Muskogee

Bob Hawley
Director, EMS of LeFlore County
Poteau

Cheryl St. Clair
Associate State Extension Specialist,
Oklahoma State University
Stillwater

Ronnie Kessler
Fire Chief, Chickasha Fire Department
Chickasha

Trish Weedn
Executive Director, Oklahoma
Association of Regional Councils
Oklahoma City

Marvin McLellan
Program Director, Medi-Flight
Oklahoma City

Executive Summary

Emergency medical service (EMS) providers form a vital public health safety net by offering life-saving care to critical and unstable Oklahomans. However, ambulance providers themselves are in a situation best described as critical and unstable. Oklahoma's EMS system is crumbling; intervention is needed to ensure access statewide.

All Oklahoma providers work on behalf of public health and strengthen our State's EMS safety net, but the similarities between providers end there. Oklahoma's EMS system is composed of a diverse mix of entities – hospital-based ambulance services, for-profit EMS agencies, services based in fire departments, city/county EMS agencies and public ambulance trusts.

Communities' methods of funding EMS varies greatly, though most Oklahoma providers collect fees for services. There is no statewide mechanism for dedicated public funding of EMS. Federal reimbursement to EMS providers has decreased dramatically over the past five years and contributed to the closure of nearly four dozen services. Thirteen communities remain orphaned and without dedicated ambulance coverage for their residents, and other communities' providers are on the brink of failure.

The lack of funding coupled with the inability to attract and retain experienced emergency physicians and veteran EMTs, particularly in rural Oklahoma, has weakened providers' ability to care for patients on a normal, everyday basis; the EMS industry is largely unequipped and unprepared to meet needs following a natural disaster or terrorist event.

Quality of EMS varies greatly from community to community. Training opportunities are costly and often inaccessible to rural EMTs and emergency physicians. Benefits afforded to firefighters, teachers and others who serve public needs are not bestowed upon EMTs. Many leave the profession for careers that offer pay and benefits more commensurate with the training EMTs require and the sacrifices they make.

Formed by Governor Brad Henry, the EMS Readiness Task Force has worked since October 2005 to evaluate Oklahoma's EMS system, to identify causes contributing to the current crisis and to develop recommendations for improving the system upon which Oklahomans rely. A number of cost-effective actions are urged to bolster EMS and improve the level of care available statewide. The broad package carries an annual cost of \$4,935,000 to \$5,860,000 and includes initiatives to encourage the proliferation of more efficient regional EMS providers, to improve EMT recruitment/retention, to better equip responders for disasters and much more. A number of no-cost legislative actions – such as raising the cap on 522 district tax assessments and providing tort protection to EMS medical directors – would also positively impact the industry.

Overview

Oklahomans who are injured in auto accidents, stricken by heart attacks or suffer other acute health crises expect and deserve to receive prompt emergency ambulance care. Emergency medical technicians (EMTs) and paramedics who man ambulances provide expert treatment during patients' most vulnerable times and ensure patients' delivery to the most appropriate treatment facilities. Like firefighters and police officers, medics (a term that applies to both EMTs and paramedics) must be on call 24 hours a day, seven days a week to respond to emergencies; the presence of this public health safety net benefits our entire community.

Unfortunately, thousands of Oklahomans no longer have access to prompt, dependable ambulance care and many others are at risk of losing their ambulance providers. The instability and unreliability of emergency medical services (EMS) in the new millennium puts Oklahoma lives at risk. The very safety net designed to sustain individuals in their times of crisis is, itself, in a state of crisis that only worsens as time passes.

Providers report responding to approximately 420,000 calls each year from patients suffering from a variety of illnesses and injuries. In many parts of Oklahoma, the local EMS agency is the sole health care provider. Unfortunately, 45 EMS providers have gone out of business since June 2000. Sick and injured residents of orphaned communities – cities and towns which have lost their dedicated ambulance provider – too often wait up to an hour for an ambulance to arrive from a neighboring community. Demand for EMS is expected to increase along with the aging of Oklahoma's population, particularly in rural Oklahoma.

Though EMS is a vital public service akin to law enforcement and fire protection agencies, the industry is diverse and fragmented. Public awareness efforts have largely failed to produce significant results. As such, the perception exists that every community has reliable ambulance service because every community has a paid or volunteer fire department. In reality, only 21 of Oklahoma's 162 ground ambulance services function as part of a local fire department; the vast majority are operated by hospitals, as third-service county or city agencies or as private for-profit companies. The quality of care given from community to community varies greatly.

Over 7,000 medics are licensed to practice in Oklahoma, all of whom are required to meet biannual educational mandates. All medics, regardless of whether they work for a fire-based EMS agency, a private ambulance company or other type of provider, work on behalf of public health and safety and strengthen the EMS safety net.

At the direction of Governor Brad Henry, the EMS Readiness Task Force has spent the past 16 months evaluating the current state of EMS in Oklahoma, identifying root causes for the current crisis and exploring possible solutions. Members of the Task Force represent all types and sizes of providers. Areas studied by the Task Force included:

- **Funding.** The lack of a dedicated funding source for EMS in Oklahoma is a critical issue that must be addressed. Most providers collect fees for service to finance operations. However, federal reimbursement for service provided to Medicare subscribers – who make up nearly half of Oklahoma EMS patients – has been dramatically reduced since 2002. Reimbursement is scheduled to continue shrinking until final implementation of the Medicare fee schedule in 2010. Other funding options, such as 522 ambulance districts, are available but rarely sufficient to cover all expenses. As federal reimbursement for service provided continues to decline, new funding mechanisms must be identified and current methods should be improved.
- **Medical Oversight and Quality Improvement.** Medical direction of EMS is as fragmented as EMS itself. Universal standards are difficult to establish. The rewards associated with a career in EMS do not outweigh the risks for physicians, thus dedicated, quality oversight is lacking. The problem is exacerbated in rural Oklahoma. Creating a State-supported medical direction network could provide improvement.
- **Personnel Training and Retention.** Recruiting and retaining sufficient EMS personnel is a tremendous challenge for providers. Compensation of medics is poor, given the training requirements and pay in comparison industries. Training requirements have grown, yet access to quality training and recertification programs is limited. Costs can be prohibitive, particularly for rural Oklahomans. Steps must be taken to improve training accessibility and to entice individuals to begin or continue a career in EMS.
- **Response/Disaster Readiness.** EMS is not receiving an equitable share of federal or State Office of Homeland Security dollars. Most Oklahoma medics have received little or no training on responding to terrorist attacks. Personnel are inadequately prepared to appropriately manage medical needs in a large-scale disaster. EMS must be integrated into Oklahoma’s disaster readiness efforts.

Further discussion of key study areas are found in the following pages. It should be noted that Oklahoma isn’t the only state facing an EMS crisis. Most states, including Texas, Arkansas, Kansas and Missouri, have lost EMS providers over the past five years and are in danger of losing more within the next five years. As economic pressures mount, more Oklahoma providers – rural and urban – will be forced to scale back operations or shut down altogether unless interventions are made.

Funding

One of a community's most critical functions is to ensure its residents quick access to life-saving emergency ambulance care. EMS, along with law enforcement and fire protection, contributes greatly to the general public safety. Unfortunately though, EMS lacks dedicated funding like law enforcement and fire protection agencies. Changes in federal reimbursement have decimated traditional EMS funding sources and thrown Oklahoma's entire EMS industry into a state of crisis.

Nearly four dozen Oklahoma providers have closed over the past seven years; in 2006 alone, six services surrendered their licenses to the Oklahoma State Department of Health's EMS Division. New and existing providers have stepped in to fill most of the voids, but residents of 13 communities remain orphaned and without access to dedicated emergency medical service. As economic pressures mount, more Oklahoma providers will be forced to scale back operations or shut down altogether.

EMS providers receive the bulk of their funding from fees for services provided to Medicare and Medicaid patients. Statewide, over half of patient revenue is derived from these two sources. However, while the number of Medicare and Medicaid patients is increasing, the amount of revenue realized from service provided to these patients is declining sharply. On April 1, 2002, the Health Care Financing Administration (now, the Centers for Medicare and Medicaid) implemented a new national fee schedule for reimbursing ambulance providers that care for Medicare members. Upon final implementation in 2010, providers' costs are expected to exceed reimbursement by an average of 27 percent. Providers are required to accept what Medicare is willing to pay, despite the fact that it does not cover costs. While the Oklahoma Health Care Authority has significantly increased Medicaid reimbursement to EMS providers, payments remain insufficient to cover costs.

Oklahoma ambulance providers are also aching under the strain of providing service to uninsured individuals. People unable or unwilling to pay for services comprise 20 to 30 percent of patients statewide. Only a fraction of the indigent care Oklahoma ambulance agencies provide meets the strict requirements for reimbursement from the Oklahoma Trauma Care Assistance Revolving Fund. There is no means of compensation for non-trauma related care, such as that given to individuals suffering heart attacks, diabetic emergencies and breathing problems. The federal government offers ambulance providers no relief whatsoever.

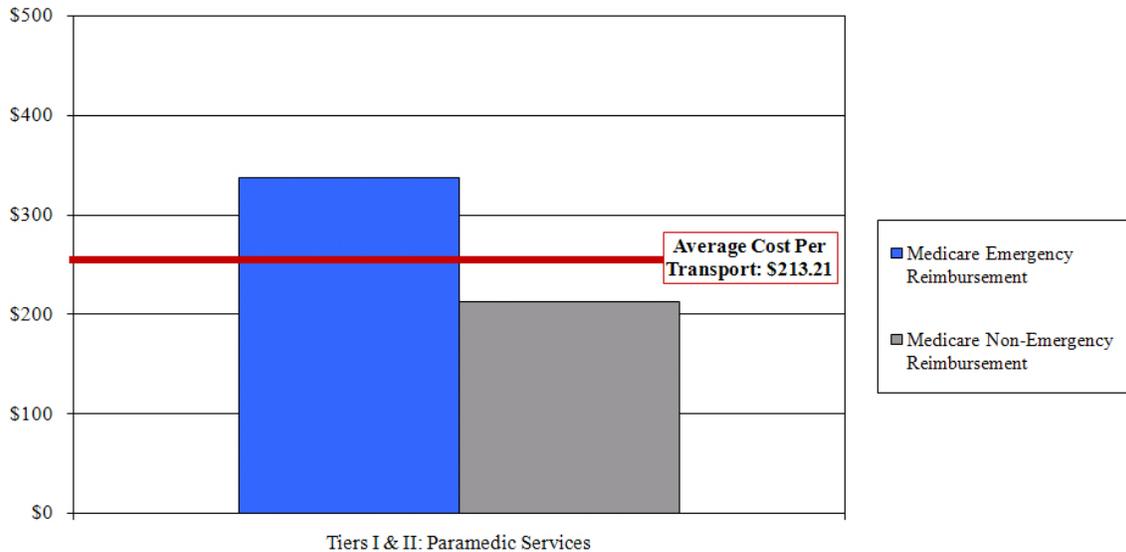
All agencies are affected by Medicare reimbursement cutbacks, yet why were some providers forced out of business while others survived? To help answer the question, the Governor's EMS Readiness Task Force contracted with The Institute for Issue Management and Alternative Dispute Resolution at Oklahoma State University to conduct a survey of a representative sample of ambulance services in Oklahoma. During the research project, ambulance services were divided into three groups based on the number of patient transports completed per year: Tier I (services completing more than 15,000 patient transports annually), Tier II (services handling 1,000 to 15,000 transports)

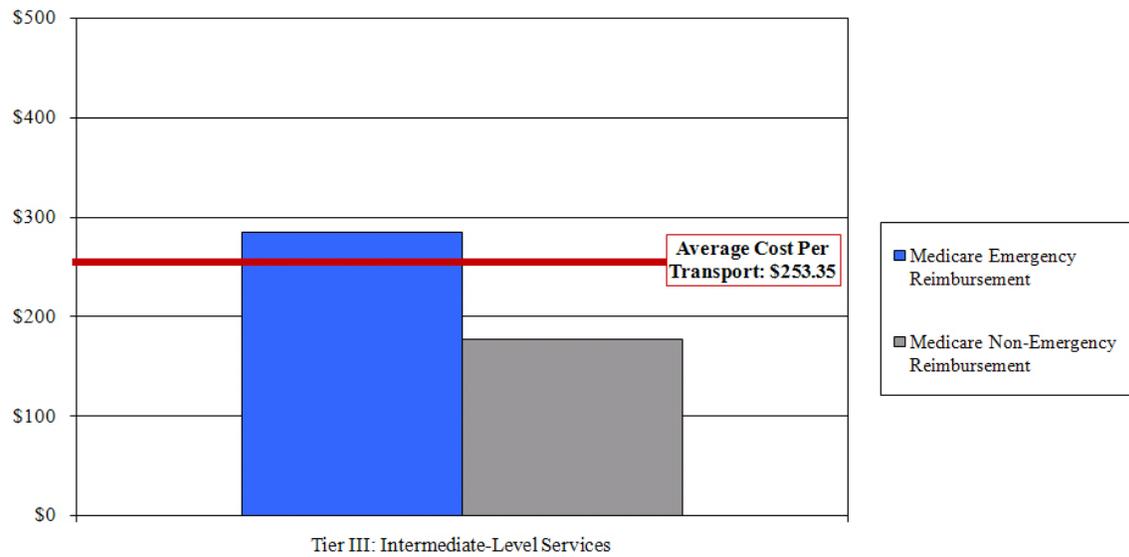
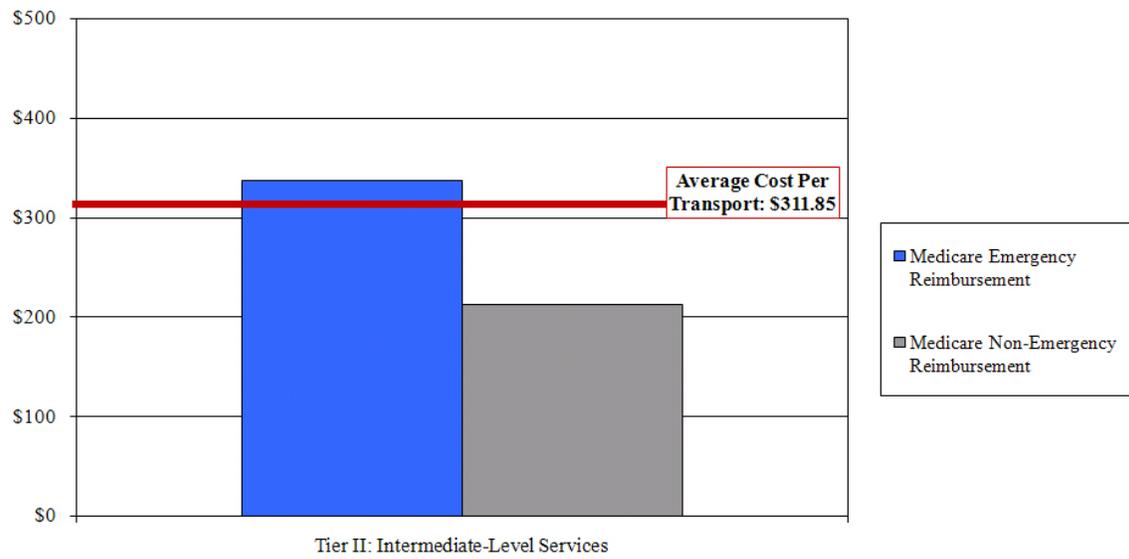
and Tier III (Oklahoma’s smallest services, with fewer than 1,000 patient transports annually).

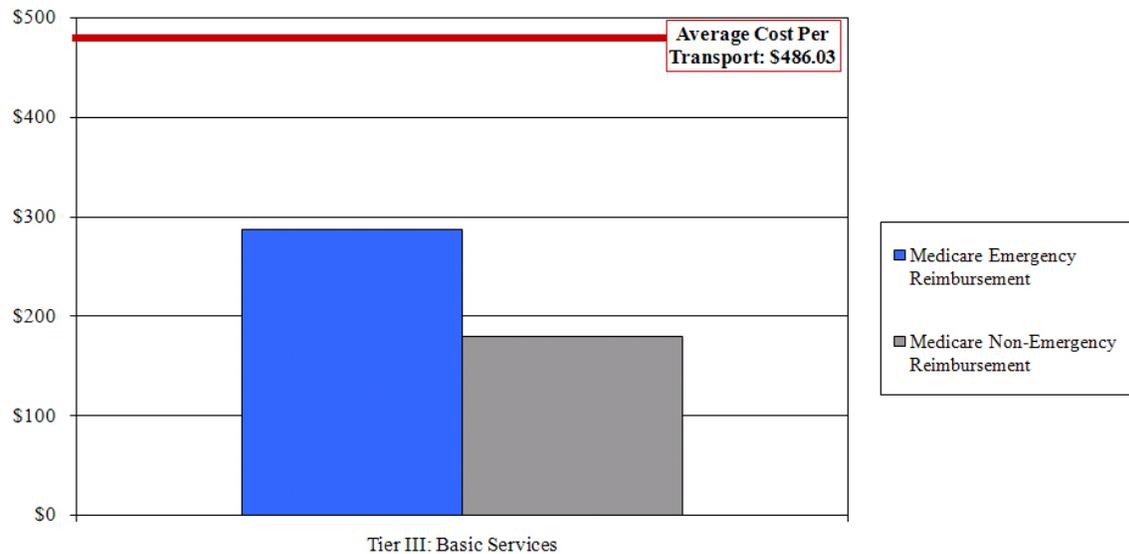
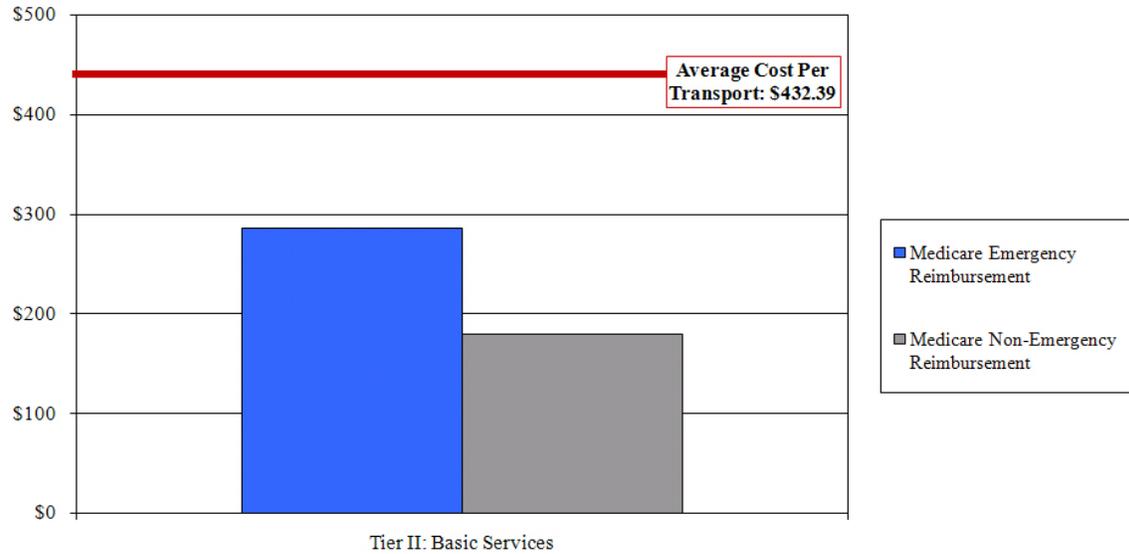
Research found that readiness costs – which make up the bulk of all providers’ expenses – result in an alarmingly high average cost per transport for Tier II and Tier III basic-level services. Though many of these services provide ten or fewer transports per week, their medics must be ready to respond 24 hours a day, seven days a week. Ensuring citizens round-the-clock access to EMS is necessary to maintain the public health safety net, but as the gap between supply of EMS and demand for EMS widens, the average cost per transport grows.

As is evident on the following charts, Medicare emergency reimbursement barely covers the average cost per transport in paramedic and intermediate-level services; there is no extra granted to offset the expenses associated with indigent care or the reduced non-emergency reimbursement. Medicare payments to Tier II and Tier III basic-level services are entirely insufficient, even with the rural add-on currently provided by Medicare.

OKLAHOMA EMS COSTS AND MEDICARE REIMBURSEMENT







- Tier I is composed of services that complete more than 15,000 patient transports per year. There are no intermediate- or basic-level services in Tier I.
- Tier II is composed of services that complete 1,000 to 15,000 patients transports per year. Medicare reimbursement displayed for Tier II basic services is a rate given to urban providers.
- Tier III is composed of services that complete fewer than 1,000 patient transports per year. There are no paramedic-level services in Tier III. Medicare reimbursement displayed is a rate given to rural providers.
- Medicare also reimburses providers for each loaded mile (miles traveled with patients on board). The rate is \$6.05 per mile for urban providers and \$6.11 for rural providers.

An oft-suggested option of raising or removing the cap on 522 Funds (Section X of the Oklahoma Constitution, an ad valorem tax specifically for EMS currently capped at three mils) would be helpful in areas where there is a population of sufficient size and sufficient income to support an ambulance service. For these areas, this option is recommended by the Task Force. However, raising or removing the cap on 522 Funds will not resolve the problem in sparsely populated areas of the State. In these communities, regionalization of ambulance services appears to be the most feasible solution.

Voluntary regionalization of EMS can deliver significant cost savings due to increased volume and the sharing of fixed costs. Functions such as dispatch, medical control, fleet maintenance, purchasing and training can be shared, resulting in the most efficient use of manpower and financial resources. Standardization of protocols and equipment, as well as a spirit of cooperation between communities and emergency medical services, are necessary to realize regionalization. Historically, financial and political differences have stymied efforts to build regional EMS systems.

Regional EMS systems offer citizens of rural Oklahoma the possibility of access to high-quality ambulance service at a more cost-efficient price than is currently available. Costs for taxpayers and EMS rate payers in regional systems are capped. To assist current systems and encourage the development of regional EMS networks, the following options could be exercised:

1. Remove the cap on 522 districts. The current three-mil ceiling is insufficient to meet many current and projected needs given the decimation of traditional funding sources.

Investment required: None

2. Provide free assessments of local ambulance providers' operations and capabilities. All types of providers (including hospital-based services, ambulance trusts, private providers and government EMS agencies) will be eligible for assessments. Assessments will be conducted on-site by experts in the field of EMS finance, management and operations, and medical direction; written reports will be presented to the governing body of the local service, and ongoing follow-up and implementation support will be provided.
 - In 2007, at least three service assessments could be performed; reports would be made to governing bodies. Accomplishing this would require the addition of one full-time employee, with expertise in EMS administration and development, to the OSDH EMS Division.
 - In 2008 and subsequent years, up to four annual assessments could be completed. Assessments may be linked to the development of regional

Medical Emergency Response Centers, described in the medical oversight section of this report.

Investment required: \$100,000 annually (2007 to 2010) for standard State salary and benefits, plus travel and expenses for expert assessment teams. Four-year total of \$400,000.

3. Provide development grants to encourage the growth of clinically excellent regional EMS systems that operate in a cost-effective manner. To qualify for a development or capital improvement grant, services must first apply for a free assessment. Two-year development grants of up to \$300,000 per proposed EMS region could be extended for a second two-year term, dependent upon progress realized in the region. Grant dollars would be used to address joint EMS training, coordination of patient transports, public safety cooperation (with law enforcement and fire protection), development of shared communications systems, education of the public and local health care facilities and system management.

- Development Grants must be available to areas where a service assessment has been completed and recommendations for improvement have been made and accepted.

Investment required: \$1.2 million annually (2007 to 2010). Four-year total of \$4.8 million.

4. Award capital improvement grants, which would match dedicated local dollars, to help ambulance services and newly developed EMS regions purchase necessary shared infrastructure (such as training equipment, radio and communications equipment, vehicles, defibrillators, computer equipment and other capital items designed to last at least three years). Capital improvement assistance must also be available to regional EMS systems at the time they commence operations.

Investment required: \$800,000 annually (2007 to 2010). Four-year total of \$3.2 million.

Over four years, funding the Oklahoma Emergency Response Systems Development project will permit free assessments to be done in 15 regions voluntarily organized by local authorities. These regions and systems within them will then be eligible for development and capital improvement grants to help them attain self sufficiency through reimbursement and local funding.

Medical Oversight/Quality Improvement

Though EMTs and paramedics work outside of a clinical setting, they do not work independent of clinical oversight. State statutes and Oklahoma State Department of Health regulations require medics to operate under the direction of a qualified medical director. This layer of oversight would be illogical if medics simply drove patients to hospitals; since medics administer narcotics and other medications, insert breathing tubes into patients unable to breathe on their own and practice other advanced medical procedures in the pre-hospital setting, supervision is necessary to confirm that standards of care are achieved.

A medical director is a fully licensed physician (doctor of medicine or doctor of osteopathy) who serves as an advisor to one or more of Oklahoma's 194 licensed ground, air and specialty care ambulance services. Medical directors monitor and regulate the treatment medics within their EMS systems provide by developing patient care protocols, being involved in medic continuing education and managing quality assurance programs. Quality of medical direction correlates to quality of care medics deliver; the lack of good oversight often equates to a lack of good patient care and puts lives at risk.

Demand for medical direction is greater than the supply of physicians willing to work in support of Oklahoma's EMS system. Furthermore, regulatory guidelines are fairly broad and do not establish universal standards for quality assurance, medical director involvement or emergency medical dispatching. What results is a troubling disarray. The most active medical oversight is found in Oklahoma's two largest cities, which share a full-time director who is board-certified in emergency medicine. In these and few other cities, 911 operators follow carefully crafted emergency medical dispatch scripting that provides immediate responses to patients in need, medics follow scientific protocols and actions are documented and scrutinized as part of a regular quality assurance process. However, the vast majority of Oklahoma communities rely solely on part-time medical control from private practice or hospital-based physicians who have precious little time to investigate complaints, conduct industry-specific research or draft and initiate new protocols. Systematic quality assurance and emergency medical dispatching are non-existent in many communities.

A number of factors contribute to the inconsistency of medical direction in Oklahoma's EMS network. The first and perhaps most difficult challenge is the shrinking professional base in rural Oklahoma. Only in urban settings can physicians receive the training needed to successfully lead EMS agencies; few physicians – regardless of where they were raised – choose to practice in rural Oklahoma. Physicians who do choose to practice in rural Oklahoma typically have less advanced training than their urban peers. Less than one-third of emergency physicians in rural Oklahoma – compared to 90 percent of their urban peers – are board certified.

The lack of financial incentives and the considerable risks associated with EMS oversight also contribute to the current medical director shortage. Sufficient caps are placed on the liability medical directors of governmental EMS agencies face, but medical directors of

private, hospital-based and other ambulance services are not legally protected. All EMS medical directors work to strengthen Oklahoma's EMS safety net, regardless of the type of system in which they work, but all aren't treated equally. Furthermore, despite the significant personal risks, more than half of EMS agencies surveyed by the Governor's Task Force do not pay their medical directors. Due to decreasing Medicare reimbursement, private medical practice has become considerably less profitable. Physicians must work longer hours, see more patients, to receive the same compensation they did in the recent past, and as a result, have less time to devote as volunteers for EMS medical direction.

Finally, it should be noted that medical direction is not second nature for most physicians. There is no collegiate-, graduate-level or continuing education on EMS medical direction available in Oklahoma. Our State's best medical directors are board-certified emergency physicians who rely on their experience in major hospital-based trauma centers, their ability to review and conduct research and their participation in national educational conferences to guide local quality assurance programs and deliver quality medical direction. Too many of Oklahoma's medical directors are part-time custodians who have limited advanced training or practical expertise in trauma and emergency medicine.

Creating a State-supported network for EMS medical direction is essential to standardizing the quality of care Oklahomans receive. The Governor's Task Force acknowledges that the presence or absence of an active medical director can affect all aspects of an ambulance service, including patient care, management, morale and personnel recruitment and retention.

The Oklahoma Institute for Disaster and Emergency Medicine has been established at the University of Oklahoma College of Medicine-Tulsa to address emergency care and disaster response through educational initiatives. The Institute will soon house an allopathic residency for emergency medicine with dedicated faculty. Recruitment efforts are currently underway for an EMS fellowship-trained emergency physician to support a variety of EMS efforts across the State. The Institute is also developing trauma educational modules identified through the Oklahoma State Department of Health Trauma Division and its Medical Audit Committee. In addition to the trauma educational modules, the Institute can support the Oklahoma State Department of Health in developing and delivering a variety of educational programs, including but not limited to development of evidence-based medicine consistent protocols, utilizing universal standards for quality assurance, and medical director training. Dissemination of educational material can be coordinated through other educational institutions, including The Oklahoma Department of Career and Technology Education facilities, and the Institute's multiple-component education platform website.

To ensure the best quality of service, the State should take the following actions:

1. Provide funding enabling the OSDH EMS Division to work with the Oklahoma Institute for Disaster and Emergency Medicine to develop

evidence-based medicine protocols, and to develop and disseminate educational curriculum such as the rural EMS medical director training programs. Training would focus on creating effective medical oversight networks and recruitment of rural EMS medical directors.

Investment required: \$150,000 annually (2007 to 2010). Four-year total of \$600,000.

2. Legislate liability protection to cap the amount of tort for all Oklahoma EMS medical directors. This would enable physicians to provide oversight, internal reviews, remediation, continuing education and quality assurance without significant risk to personal wealth.

Investment required: None

3. Protect EMS quality improvement/quality assurance programs from legal discovery (similar to the protections provided in our State trauma system). Such protection would minimize physician liability and encourage more active evaluation and review processes.

Investment required: None

4. Dedicate State funds to ensure continued development of five Medical Emergency Response Centers (MERCs), in the event of federal reprioritization. Current MERC funding is provided by the federal government but is in danger of being reduced or eliminated. Each MERC should provide organized emergency medical dispatching for the entire region and would employ a qualified physician to coordinate and support medical direction within the MERC region. The coordinating physician would be a member of a statewide EMS panel assuring the provision of quality EMS medical direction throughout Oklahoma.

Investment required: \$375,000 annually *should federal funds be eliminated.*

Personnel Training and Retention

The majority of personnel licensed to provide EMS care in the State of Oklahoma are emergency medical technicians (EMTs) trained to complete basic life support procedures. Less than a quarter of Oklahoma's EMS workforce hold paramedic licensure, a certification permitting them to provide the highest level of pre-hospital medical care, including administration of medications, cardiac monitoring, and placement of endotracheal tubes in respiratory/cardiac arrest patients. The highest concentrations of paramedics are found in urban settings; paramedic-level service is available in only 25 of Oklahoma's 77 counties.

Oklahoma's EMS providers are struggling to find and retain qualified, dedicated personnel because medic salaries are stagnant and non-competitive. EMT and paramedic wages are not commensurate to other similarly-educated professions, and benefits are paltry in comparison to those given firefighters, police officers and other public safety personnel.

So just how bad is the pay? The two-year Associate of Science in Nursing track widely utilized by registered nurses is similar in length and scope to the two-year paramedic training course. Both are much more intensive than the 154-hour minimum requirement for EMTs. Yet registered nurses get paid nearly double what EMS personnel make, on average. Law enforcement officers, firefighters and licensed practical nurses all require similar or less training than EMS personnel, yet police, firefighter and nurse wages are \$8,000 to \$13,000 greater than mean EMT and paramedic salaries.

OKLAHOMA WAGE COMPARISON

<u>Profession</u>	<u>Mean Annual Salary</u>
Registered Nurses	\$47,546
Police & Sheriff's Officers	\$35,188
Firefighters	\$34,797
Licensed Practical Nurses	\$29,820
EMTs & Paramedics	\$21,886

SOURCE: Oklahoma Employment Security Commission, Occupational Wage Network data collected during the years of 2002, 2003 and 2004 Occupational Wage Survey, website: <http://www.oesc.state.ok.us>

What medics lose in wages is not made up in benefits. There is no systematic approach to or dedicated public support for providing insurance or retirement benefits for EMTs and paramedics, as there is for law enforcement officers and firefighters in Oklahoma. Despite the fact that medics, like other public safety officers, respond to natural disasters and terrorist incidents, deal with violent patients and risk their lives to serve others, there is no line of duty death benefit for medics commensurate with police and fire.

Many medics leave EMS to secure better-paying jobs in the comparison industries listed above. Some Oklahoma nursing schools offer bridge programs specifically targeting paramedics for the transition to nursing. Fire departments functioning only as first response agencies also lure away experienced EMTs and paramedics with the promise of better pay and guaranteed benefits.

In addition to the wage disparity, training and recertification hindrances drive many medics out of EMS jobs. Paramedic students are required to complete 392 hours of clinical work; EMT candidates need 24 clinical hours. Plus, experienced EMTs and paramedics are required to complete 72 hours of continuing education every two years. Students from rural settings and veteran volunteers must travel, often at their own expense, to a metropolitan facility to complete the requirements. Travel expenses and time away from work and family are more than many Oklahomans, and particularly those intending to join volunteer squads, can or will bear.

Training and recertification opportunities are almost non-existent in rural Oklahoma. As a result, rural students forsake careers in EMS or relocate permanently to urban settings, and veteran volunteers allow their licensure to lapse. Requirements are burdensome and are negatively impacting the ability of EMS providers to attract and retain key personnel.

An imminent, unfunded training mandate could have a frightening impact on the size of Oklahoma's EMS workforce. Starting in 2010, graduation from a nationally accredited training program will be a prerequisite for taking the EMT National Registry paramedic exam. Only one paramedic training associate degree program in the State of Oklahoma is nationally accredited; there are no accredited EMT courses. Oklahoma Department of Career and Technology Education centers, which provide training for 90 percent of Oklahoma EMTs, lack national accreditation. The Oklahoma State Department of Health has recommended that Career Tech standardize EMT education at all sites, but the shortage of qualified instructors, clinical opportunities and funding are significant barriers to standardization. Utilizing distance education techniques could be a cost-efficient and effective solution.

There are a number of actions which could aid in recruitment and retention.

1. Provide a funded mandate to enable Career Tech to expand EMS distance education in rural Oklahoma and to assist Career Tech in meeting the 2010 national accreditation requirement.

Investment required: \$675,000 in start-up costs (2007); \$250,000 annually (2008 to 2010). Four-year total of \$1,425,000.

2. Initiate a study to determine the feasibility of providing a statewide pension plan, commensurate to plans offered to Oklahoma firefighters and law enforcement officers, to all EMTs and paramedics.

Investment required: None.

3. Provide “line of duty” death benefits, commensurate to plans offered to firefighters and law enforcement personnel, to all EMTs and paramedics actively working to sustain Oklahoma’s EMS safety net.

Investment required: \$10,000 per incident (2007 to 2010). Expected four-year cost of \$40,000.

4. Support legislation providing a \$400 tax credit for EMTs and paramedics actively working to sustain Oklahoma’s EMS safety net. Approximately 2,500 medics would qualify for this benefit each year.

Investment required: \$1,000,000 annually (2007 to 2010). Four-year cost of \$4,000,000.

5. Award grants, scholarships and free training opportunities, similar to the Physician Manpower Training Commission recommendations for nurses, to EMTs and paramedics, particularly those working in support of rural EMS.

Investment required: \$300,000 annually (2007 to 2010). Four-year cost of \$1,200,000.

6. Provide a State tuition reimbursement of up to \$3,000 for EMTs who complete advanced training and work at least 1,000 hours each year for two years to sustain Oklahoma’s EMS safety net.

Investment required: \$750,000 in 2007; \$925,000 in 2008; \$1,850,000 annually in 2009 and 2010. Four-year total of \$5,375,000.

Response/Disaster Readiness

When responding to natural or manmade disasters, emergency responders have three priorities – life safety, incident stabilization and property conservation. Saving lives is the first and most important goal. However, a disproportionately small share of Homeland Security funds and training opportunities have been made available to EMS. As a result, the very people charged with providing medical care at disaster scenes are inadequately trained and insufficiently equipped to respond to the call of duty.

After the bombing of the Murrah Federal Building, Oklahoma became one of the nation's leaders in disaster response and readiness. Disaster training became a national priority in the months following the September 11, 2001 World Trade Center attack. Yet despite more emphasis placed on Homeland Security, EMS has received dramatically less funding and many fewer training opportunities than other emergency responders.

According to a report released last year by New York University's Center for Catastrophic Preparedness and Response, EMS providers received only four percent of the United States Department of Homeland Security's first response dollars in 2002 and 2003. The allocation is insufficient given the role EMS provides in times of disaster and the size of the EMS workforce, estimated to comprise one-third of all emergency response personnel. Congress refused this year to add language to the Homeland Security Appropriations Bill that would have required at least ten percent of funding be assigned to EMS providers.

On the State level, the Oklahoma Office of Homeland Security (OKOHS) issued \$383,865 to EMS agencies – just over one percent of the total \$35.7 million allocated – between 1999 and 2003. Oklahoma EMS providers have received little guidance on how to obtain funding and are largely unaware of available resources.

It should also be noted that unlike the law enforcement and fire protection services, which are organized, government-based and backed by national unions that excel in securing federal dollars, the EMS industry is composed of a diverse mix of private, hospital-based and governmental providers who have relatively little statewide or national influence. All providers contribute to Oklahoma's EMS public health safety net, yet private providers (nearly 50 of whom operate in Oklahoma) have been largely excluded from grant opportunities designed to strengthen their disaster response capabilities. Recent amendments to the Homeland Security Act clarified that both public and private providers are eligible for funding.

Oklahoma providers' inability to obtain needed funding and support has led to serious lapses in training. Oklahoma EMS personnel have not, for the most part, received instruction on caring for patients during a terrorist attack or natural catastrophe. A majority of our EMS workforce has received less than one hour of training in biological, chemical and explosive hazards; most EMTs and paramedics have received no instruction. Furthermore, EMS personnel are not afforded regular opportunities to drill for terrorism scenarios.

Without adequate funding, EMS providers have been unable to equip themselves for disaster response. When EMTs and paramedics respond to a scene without personal protective gear, they risk becoming victims themselves; by not protecting our medics, we risk not having emergency medical services available when needed most. Though there are a number of regional response assets for hazardous materials response placed strategically across Oklahoma, there has been no stockpiling of essential medical equipment, response vehicles or personal protective equipment. Surge capacities are extremely limited, particularly in rural Oklahoma, yet there has been little pre-planning and few contingency plans developed to manage a large-scale EMS response.

To address the equipment needs, OKOHS collaborated with OSDH to create the EMS Package Plan. Funded with FY 2006 State Homeland Security Grant Program and Centers for Disease Control/Health Resources and Services Administration funds, the package plan will increase and enhance the capabilities of Oklahoma's EMS providers. Under the plan, providers willing to participate in Oklahoma's Regional Medical Response Systems may receive funds to purchase equipment.

Communication problems also pose a substantial roadblock to Oklahoma's disaster readiness and response efforts. In a statewide emergency, there would likely be no immediate interoperability between EMS agencies and other responders or the public health system; it is possible in a large-scale disaster that responders would be unable to communicate with each other or coordinate initial rescue/response efforts. VHF radio systems installed years ago to facilitate disaster communications between hospitals and EMS providers sit idle; funding is not available to maintain equipment or drill personnel on usage. Federal "drop-in" communication networks would provide needed infrastructure in the second phase of a mass-casualty incident but would not be available for responders during the key first hours after a terrorist attack, massive tornado or other disaster. Furthermore, Oklahoma's burgeoning 800 MHz system will not function in some parts of the State, including much of southeast Oklahoma, due to the topography. Improving statewide communication systems is a goal of the Oklahoma Office of Homeland Security, but inadequate funds have been allocated to achieve EMS interoperability.

Ensuring that EMS providers are fully prepared to respond to terrorist attacks, tornadoes and other large-scale disasters is key to minimizing the human impact of such incidents. If EMTs and paramedics are ill-equipped for the worst-case scenarios, their ability to care for victims will be significantly compromised. The following actions are necessary to help save lives:

1. Revise and update the Oklahoma Wide Area Communications Plan to provide a practical template for EMS providers. VHF radio frequencies are set aside and should be designated for common emergency responder use during large-scale incidents. Using the existing frequencies would minimize costs and ensure a common platform for communications.

Investment required: \$200,000 annually for 4 years to support a grant program to upgrade current radios.

2. Create partnerships between private-sector EMS providers and local governmental agencies to help agencies secure more funding from OKOHS. Devising a system that awards funding to private agencies yet guarantees assets remain in the community for which they were intended would best protect all citizens. State recognition of private providers' role in sustaining our EMS safety net is crucial to validating the partnerships and protecting all Oklahoma communities.

Investment required: None

3. Dedicate State funds to ensure the continued development of regional response teams. Current funding is provided by the federal government but is in danger of being reduced or eliminated. Regional response teams would operate under Oklahoma's emergency operations plan and be patterned after the existing Chemical, Biological, Radiological, Nuclear, Explosive (CBRNE) Teams.

Investment required: \$1,600,000 annually (\$200,000 for each of eight teams) *should federal funds be eliminated.*

Summary

Though Oklahoma ambulance providers are charged with caring for patients in their times of crisis, the industry itself is facing a mounting crisis. Oklahoma EMS relies on fees for services to support operations, yet reimbursement from government payers is insufficient to cover providers' costs. There remains no statewide, dedicated funding mechanism to sustain Oklahoma's EMS safety net. Quality of EMS is inconsistent from community to community; in some cases, there simply is no dedicated service upon which residents can rely. Educational opportunities are costly and particularly scarce in rural Oklahoma, thereby hindering the ability to grow an ample EMS workforce. Because pay and benefits not comparable to what firefighters and others who work to benefit public health and safety receive, retaining medics is also a challenge. EMS has received fewer federal and State Homeland Security dollars, thus its workforce lags behind other emergency responders in disaster response and readiness.

The Governor's Task Force recommends a number of actions to help assuage the crisis and improve the level of EMS available to Oklahoma patients. Some ideas – including the Oklahoma Emergency Response Systems Development project – are patterned loosely after other State's efforts, including an EMS management training program in Utah. Utah health officials report that participating providers have improved their collection capabilities, been able to increase EMT compensation and ensure an adequate rural workforce.

Utah and at least two Oklahoma EMS agencies also provide tuition reimbursement to medics seeking advanced training. From 2004 to 2006, Oklahoma providers paid to send 41 employees through paramedic training programs in returned for work commitments.

Distance education has also yielded positive results. A program started six years ago at Kiamichi Technology Center graduated 28 paramedics in 2006; the program had been on the verge of closing due to low enrollment or one to two students per class. Distance learning has also been successfully used by the military and nursing programs.

It stands to reason that affording firefighter-equivalent benefits to EMTs will reduce the number of EMTs departing EMS for the fire service and other more lucrative fields. Offering comparable tax credits and death benefits are only part of the solution. As EMTs work on behalf of public health and safety, just as firefighters and law enforcement officers do, one must ask whether EMTs should be eligible to join the same type of publicly-supported pension program to which firefighters and law enforcement officers belong.

Requests for Funding

	2007	2008	2009	2010
Oklahoma Emergency Response Systems Development project: operational assessments	\$100,000	\$100,000	\$100,000	\$100,000
Oklahoma Emergency Response Systems Development project: development grants	\$1,200,000	\$1,200,000	\$1,200,000	\$1,200,000
Oklahoma Emergency Response Systems Development project: capital improvement grants	\$800,000	\$800,000	\$800,000	\$800,000
Medical director training initiative	\$150,000	\$150,000	\$150,000	\$150,000
Expansion of Career Tech distance education	\$675,000	\$250,000	\$250,000	\$250,000
Line-of-duty death benefit for EMTs	\$10,000	\$10,000	\$10,000	\$10,000
EMT tax credit	\$1,000,000	\$1,000,000	\$1,000,000	\$1,000,000
EMT training grants	\$300,000	\$300,000	\$300,000	\$300,000
EMT tuition reimbursement	\$750,000	\$925,000	\$1,850,000	\$1,850,000
Improvements to the Oklahoma Wide Area Communications Plan	\$200,000	\$200,000	\$200,000	\$200,000
TOTAL	\$5,185,000	\$4,935,000	\$5,860,000	\$5,860,000

Other Requests (no funding required):

- Eliminate the cap on 522 districts
- Provide tort protection for EMS medical directors
- Protect EMS quality improvement/quality assurance programs from legal discovery
- Commit to using State funds for the continued development of Medical Emergency Response Centers, should federal funding streams evaporate. In the event of federal withdrawal of support, cost would be \$375,000 annually.

- Initiate a study to determine the feasibility of including EMTs in a statewide pension plan.
- Commit to using State funds for the continued development of regional response teams, should federal funding streams evaporate. In the event of federal withdrawal of support, cost would be \$1,600,000 annually.
- Increase OKOHS funding allocated to Oklahoma EMS providers