PENNSYLVANIA EMERGENCY HEALTH SERVICES COUNCIL

*Your Voice In EMS*

# TESTIMONY

# TO THE

# COMMONWEALTH OF PENNSYLVANIA

# VETERANS AFFAIRS

# &

# EMERGENCY PREPAREDNESS

# COMMITTEES

Senate Resolution 60 - Commission of 2004

August 23, 2016

600 Wilson Lane, Suite 101 • Mechanicsburg, PA 17055-4527 • (717) 795-0740 • (800) 243-2EMS • FAX (717) 795-0741
pehsc@pehsc.org • www.pehsc.org

Members of the Pennsylvania House and Senate Veterans Affairs and Emergency Preparedness Committees, I am Janette Swade the Director of the Pennsylvania Emergency Health Services Council. The Pennsylvania Emergency Services Council has been recognized as the statewide advisory board to the PA Department of Health since 1985. Thank you for this opportunity to comment on the SR 60 initiative.

As you know, the intent of the original SR 60 legislation was to provide legislative support for direct and indirect assistance to improve the delivery of emergency services in the Commonwealth. If we continue with this concept, it is important to consider the following general recommendations for EMS in the forefront.

We offer 3 general thoughts in regard to this process.

First, the cultural and geographic diversity of EMS in Pennsylvania is a significant challenge to any process. The diversity in EMS will make some of the SR 60 recommendations appealing to some agencies and providers and not to others. In reality, the view from the field tends to follow the logic that volunteer or paid the job remains the same so the benefits should be provided to all. This is a challenge as we move forward. The role of the PEHSC is to be the voice for all of the agencies and providers and, as such, we, with the assistance of our member organizations will attempt to offer solutions to meet the needs of both paid and volunteer personnel and agencies.

Simply, we offer that some of the existing SR 60 recommendations should be expanded beyond the volunteer description. It seems that our efforts in this regard would still meet the intended legislative goal to improve the delivery of EMS throughout the Commonwealth.

Second, the EMS system funding model from 1985 is no longer able to support system needs. The established fund for EMS is solely dependent on the issuance of traffic violations. Most recently, the allocation of funds has again been decreased causing across the board reductions to regional councils and hence to provider agencies and services, plus to the rehabilitation services who manage the head injury program. Although we understand the need for system wide efficiencies, the impact of this recent reduction of the fund is not a result of a planned management decision; sadly it is directly relational to the availability of funds. When it became clear that this fund decrease was imminent, we made some legislative inquires to determine the reason for the decrease. One legislative staff person responded to us with, "great news the number of traffic violations were less, people must be driving safer." While that is a nice sentiment and a goal for society, we simply cannot be linked to something that can no longer support our structure. What would happen if we experienced a statewide situation where existing resources needed to be increased? Where would this funding come from? In the past we were able to mitigate this scenario with the EMS Operating Fund because it actually had surplus monies, this is no longer the case. Third party reimbursement reform should not be ignored in the goals of SR 60; however it has never been able to support the true cost of delivery or the cost of readiness. We need a reliable self-sustaining funding source that can support clinical advancements and system growth for the future.

Further, the administrative needs of the system continue to suffer from the state budget limitations. The Bureau of EMS remains understaffed. In comparison to other states our "state office" does not have a comparable staffing compliment for the number of providers, agencies, and the statewide call volume. Pennsylvania has been a model state for years, we need to not only maintain our national standing, but make it a priority.

We request that providers, agency and system funding for EMS be a priority for the SR 60 recommendations. Our call volume continues to grow as does the clinical care for our patients yet the system funding model lingers in 1985.

Lastly, the declining workforce is becoming more and more noticeable. In my 25 years of service as an EMT I have never seen offers to hire providers with a sign on bonus but this type of recruitment has begun. We are also hearing more and more staffing shortage concerns from our members. I feel confident in saying EMS is also approaching a staffing crisis, not just a shortage, like the fire service. We already know that the staffing for EMS in volunteer agencies has been declining and has been in crisis - now this trend seems to be growing. The question remains, unanswered "Why are people not becoming EMS providers or staying in the industry?"

Without a comprehensive study we can only take an educated guess which includes the following factors.

This line of work is only of interest to a limited number of people. You need to have certain abilities and a unique skill set to function in the field.

The wages paid to EMS providers are so low that most providers' careers last less than 10 years. We do not retain many providers as in years past because EMS has become a feeder for other health professions or for those seeking a paid position in the fire service, where they can make more money. Many providers must work 2-3 EMS jobs to make enough money to support their families; this as you can imagine, leads to "burn out" and even mental health issues from the stress of the profession. The low wages for EMS providers obviously impacts our ranks and staffing models but it also could eventually compromise our clinical growth with the number of seasoned, lifetime EMS providers declining with no one to take their place.

This low wage situation is linked to the low reimbursements and the increasing costs to conduct business. Unlike other businesses we simply cannot raise our fees to manage these costs. And, as you know our insurance payment issues continue to be well below the cost of providing the service. Further, financial support from local government is spotty and often not a reliable source of support for the agencies.

The ability for EMS providers to translate their skill set to other careers is limited. This concept, of course could be viewed as a hindrance to keeping providers, yet the inability of any career field to have any upward mobility is a factor that is often considered by potential students. The EMS Act does allow for the development of the community paramedic or as it is also known, mobile

integrated health care. This opportunity is currently under development and should provide some recruitment/retention support for many of our providers. This is the only opportunity most providers would have to translate their years of experience and education into another health care model. Also, the ability to move into desk positions for most field providers does not exist.

The decline of providers both volunteer and paid should be addressed as should the conceptual expansion of community based care thorough the community paramedic or any equivalent initiative.

Thank you for this opportunity, we are pleased to participate in the efforts to revisit the intent of the SR 60 report with the development of new and revised recommendations.