

**75<sup>th</sup> Legislation Report  
Recommendations  
1996  
Status of Recommendations  
August 2001**

<b>Recommendations</b>	<b>Options</b>	<b>Date to be implemented</b>	<b>Current Status</b>	<b>Comments</b>
<p><b><u>Statewide EMS Force:</u></b> It is recommended that an <u>EMS Fund</u> be established from which monies can be dispersed in a variety of ways for specific purposes.</p>	<p><u>Reserve program:</u> Corps of volunteers to assist small, isolated communities faced with closure of service or short term staffing shortfalls.</p>	1997-1999	Not implemented.	State funds were not provided.
	<p><u>Equipment Lending Depot and EMS Education Service Center:</u> Equipment stockpile at regional level (RAC), from which a small provider can replace needed equipment while permanent replacement is on order. This Lending Depot can also be used to loan training equipment and supplies.</p>	1999-2001	Not implemented	State funds were not provided, however, this strategy is recommended to EMS Providers, RACs, etc.
	<p><u>Mobile Training Unit (MTU) Program &amp; Outreach instructors:</u> There is a call to increase availability of MTUs by adding three equipped training vehicles to the three already operated by the program.</p>	1999-2003	Implemented, then abandoned	This was found to be an inefficient and ineffective use of resources.
	<p><u>VISTA Volunteers:</u> In some areas of the state, staffing is an ongoing problem because there are not enough persons who want to work in EMS. Recruiting persons from outside the area has been difficult because of the low call volume and the very low pay rate, if there is any pay at all. VISTA volunteers could be trained and sent to these remote areas for one to two years, lending continuity and giving them the opportunity to integrate with community.</p>	1997-1999	Not implemented	State funds were not provided.

<b>Statewide EMS Force</b> (continued):	<u>Partners in Healthcare Program (Temporary staff)</u> : Develop a core group of volunteers that travel throughout the state on temporary assignments. Participants would be reimbursed by the day in addition to reimbursement of expenses.	1997-1998	Not implemented	State funds were not provided.
	<u>Partnership Program</u> : This program can be specifically designed for those volunteers who are willing to partner with a remote provider, and travel there monthly to work two shifts so that the local EMS person can have a day off from call. Travel expenses that cannot be borne by the local community can be paid through this fund.	1997-1998	Not implemented	State funds were not provided.
	<u>Regional Medical Direction Program</u> : For years physicians have supported EMS activities, in most cases for little or no remunerations. As responsibilities in increase, the job becomes more labor-intensive. All providers should have medical direction, and it is mandated for advanced providers. If the legislature were to make provision for regional medical direction by supporting a paid position for an emergency physician within the RAC network, medical oversight would be ensured.	1999-2000	Not implemented	State funds were not provided, however, this strategy is recommended to RACs, EMS Systems, etc.
	<u>Cooperative Purchasing Program</u> : This program would give the rural and frontier EMS providers the same economies of scale advantages that large systems enjoy. Seed money is needed to implement such a program, which would eventually become self-supporting.	2005-2010	Not implemented	State funds were not provided, however, this strategy is recommended to RACs, EMS Systems, etc.
	<u>Administrative support</u> : In all EMS systems, available resources do not cover needs. This is true for private providers as well as not-for-profit and volunteer services; even though the more dramatic examples are in rural areas, where tax revenues are low.	1999	Working	This is an allowable expenditure of the EMS/Trauma systems grant funding provided to EMS Providers, EMS Education Programs, RACs, etc.

<p><b>Statewide EMS Force</b> (continued):</p>	<p><u>Incentive programs</u>: People who are willing to make the initial and ongoing time commitment to volunteer for EMS are on the decline. Incentive programs could change this trend and assist in keeping EMS volunteerism viable until such time as counties and cities are willing to take on full responsibility. Examples of incentive programs would be: paying for workman's compensation, paying for volunteer immunizations, choosing to decrease or write-off one of the utility bills, and paying health insurance cost for volunteers. It is suggested that counties be allowed to apply for <u>some</u> assistance with these programs based on need criteria.</p>	<p>1997-1998</p>	<p>Not implemented</p>	<p>State funds were not provided.</p>
	<p><u>Scholarship program</u>: Many persons who like to actively participate in the EMS system cannot do so because of initial training costs. Even specialty courses such as Advanced Trauma Life Support (ATLS), Advanced Cardiac Life Support (ACLS), Basic Trauma Life Support (BTLS), or Prehospital Trauma Life Support (PHTLS), Pediatric Advanced Life Support (PALS), Pediatric Prehospital Provider Course (PPPC), and Trauma Nurse Core Curriculum (TNCC) are too expensive for many within the state. Yet they increase the skill levels of all members of the emergency health care team.</p>	<p>1999 - 2001</p>	<p>Not implemented on a state level.</p>	<p>Scholarship programs are an allowable expenditure of the EMS/Trauma systems grant funding provided to EMS Providers, EMS Education Programs, RACs, and Hospitals and many grants have been awarded for such.</p>
	<p>It is recommended that a <u>health insurance pool</u> be established for EMS providers.</p>	<p>2000 - 2001</p>	<p>Not implemented</p>	<p>State funds were not provided.</p>
<p><b>Additional Volunteer Incentives:</b> It is recommended that a program be set up so that a volunteer could earn one semester of tuition at a state college or university, in exchange for one year service as an active EMS volunteer in a frontier area of the state.</p>		<p>2005</p>	<p>Not implemented to date</p>	

<p><b>Medical Direction:</b> It is recommended that a clause be added to Chapter 773, Health and Safety Code, Section 773.006, dealing with medical direction of EMS, which would give some degree of <u>immunity</u> to medical directors who supervise EMS providers.</p>		1997	Not implemented	To date, liability related to medical direction has not been a major concern in Texas.
<p>It is recommended that by 2007 all EMS providers will be <u>mandated to have a medical director</u>.</p>		2005 - 2007	Completed	All EMS Providers are required to have a Medical Director (157.11) as they complete their new licensing cycle.
<p><b>Improved Patient Service and Care:</b> It is recommended that by the year 2005, each ambulance run shall have <u>minimum staffing</u> of two emergency technicians (EMTs). Emergency Care Attendants (ECAs) may continue to go on calls as a third person and may serve as first responders.</p>		2003 - 2005	Not implemented to date	Constituency concerns have not allowed implementation to date. This would require a change in the current law.
<p>It is recommended that by the year 2007, the state contract with well established <u>rotor-wing EMS providers</u> to set up sub-bases to respond to those areas of the state presently not covered by helicopter services.</p>		2005 - 2007	Not implemented to date	State funds have not been provided to date. Air ambulance is now available over the majority of the state, except extreme west Texas.
<p>It is recommended that a fifth level be added to the EMS personnel structure = <u>licensed paramedic</u>. This person who would still function under the direction of a medical director, would have a minimum of an associate's degree and be trained in additional healthcare skills as determined by national, state and local standards.</p>		1997 - 1998	Completed	Associate degree will be required as of 9/1/2002.
<p>It is recommended that <u>fees</u> be increased for <u>facility trauma designation</u>.</p>	<p>Proposed fee: Level I - \$5,000 flat fee Level II - \$4,000 flat fee Level III - \$2,500 flat fee Level IV - \$1,000 flat fee</p>	1997	Not implemented	Constituency concerns did not allow implementation. This would require a change in the current law.

<p><b>Community Incentives:</b> It is recommended that a <u>key rate system</u> for insurance be built for the EMS system, similar to the one used for fire insurance rates.</p>		2003 - 2005	Not implemented to date	
<p><b>Communications:</b> It is recommended that a voluntary certification be established for <u>emergency medical dispatchers</u> (EMD).</p>		1997	Completed	
<p>It is recommended that by the year 2003, all telecommunicators who dispatch EMS providers shall have <u>EMD certification</u>.</p>		2001 - 2003	Working	Currently, TDH certifies EMD instructors who may certify individual dispatchers. However, this process is not mandated.
<p>It is recommended that an additional eight (8) to ten (10) <u>radio towers</u> be placed throughout the west Texas areas of Presidio, Brewster, Jeff Davis and surrounding counties.</p>		2001 - 2005	Not implemented to date by TDH	State funds were not provided to TDH for this purpose. It is unknown if this has been accomplished by another agency.
<p><b>Provider Resources:</b> It is recommended that Local Projects Funding be increased to \$5.5 million for the biennium.</p>		1997 - 1999	Not implemented	LPG funding reached a high of \$2 million in FY00. For FY02, it will be ~\$1.4 million.
<p><b>Housekeeping, Cleanup &amp; Revisions:</b> It is recommended that the EMS <u>administrative penalty</u> be raised from a maximum of \$250/day per penalty, to a maximum of \$1,000/day; and the funds be used to support the auditing/investigation program.</p>		1997	Completed	Note: the additional funds are not provided back to BEM.

<p><b><u>Housekeeping, Cleanup &amp; Revisions</u></b> (continued):</p> <p>It is recommended that the state put money into <u>EMS/trauma system development</u> and coordination at both the state and regional levels.</p>		1997	Completed	<p>In 1997, the Texas Legislature provided for \$2,000,000/year in 911 Funds for EMS/Trauma System development. These funds are allotted as follows: \$250,000 extraordinary emergencies, 70% of remaining funds for EMS, 25% for RACs 2% for uncompensated trauma care, and 3% for administrative costs.</p> <p>In 1999, the Texas Legislature established a \$100,000,000 EMS and Trauma Care endowment. For the FY00/01 biennium, up to 5% interest was appropriated for EMS/trauma system grants; for the FY02/03 biennium, up to 4.5% interest has been appropriated.</p>
<p>It is recommended that clarifying language be added to Chapter 773, Health and Safety Code, Section 773.095, to make certain that records of hospital(s) quality improvement (QI) programs or committees of the RACs involved in review of care within the region, are <u>protected from disclosure</u>.</p>		1997	Completed	
<p>It is recommended that counties be <u>mandated to provide oversight</u> of EMS availability making certain that emergency medical response is given equivalent consideration to fire protection.</p>		1997 - 1999	Not implemented	<p>Constituency concerns did not allow implementation (this is viewed as an unfounded mandate by the counties).</p>