

EMS PROVIDER SURVEY COMMENTS

Prepared by

Lee Sweeten, EMT-P

¹Director of EMS Programs

TDH, Region 8

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Of 272 “**Part B**” surveys returned, 261 had the questions relating to salary completed and 45 or approximately 17% had additional comments included. These comments were reviewed and grouped into the categories listed below. An attempt was made to place each comment in the appropriate category and when a comment crossed over it was included in each of the categories it pertained to. Bullets indicate comments are from the same individual. Comments were copied as is with no attempt to correct spelling and/or grammar.

Data Collection (2)	Funding (15)	Medical Direction (6)
Personnel (7)	RAC Issues (11)	Rules and Changes (16)
Training (21)	Wages (10)	Rural Issues (13)
Miscellaneous (35)		

DATA COLLECTION

There were 2 comments relating to this area.

- Where does all the information we send to the Trauma TXEMS go. Seems like the information you asked for could be gotten off that program! Why are we sending it in?
- The system utilized for data entry is not working and does not give useful information in return.



There were 15 comments relating to this area.

FUNDING

- We have not funding in our County & must depend on our volunteer for their time fund raising donations & memorial billing for our daily running expenses & a grant for equipment. Our work force is running out because nobody wants to do something for nothing anymore!
- Medicaid claims submitted have been rejected many times. We do not transport patients just to receive reimbursement. This has to be improved. Medicare lowered reimbursement and it is killing off small services right and left. We have to find a way to fight this.
- Increased cost & lowered reimbursement = DEATH (slow but sure).

- We are a rural/frontier all volunteer ambulance service in an unincorporated community with no taxing power. Funding for our service is mainly from contributions from our small farming community
- If the State funded people within the community to run the ambulance service would this be a better alternative? This would allow people who had to leave the community, to make a living, stay in the community and work for the well being of their neighbors.
- Would it be feasible to give tax breaks to volunteers to help them stay in economically depressed areas. Since Texas does not have a statewide income tax then any tax breaks would have to be carried by local districts so already poor schools would get poorer, and counties struggling to provide minimum services would be unable to do so. It may take a new form of taxation. Perhaps a statewide EMS district to replace current hospital districts and also tax those peoples not in current taxing districts. Monies collected would be used to provide paid personnel for the ambulance services.
- Give to the rural services, that are really trying to make it. I'm not asking for 100% funding, but distributing money to assist in training, community involvement programs, computers, and capital equipment procurement. I know there is the Grant Program put on by TDH, however categorize services into groups according to size. Then distribute the money accordingly. I do not think larger tax supported entities should be eligible for the same amount of money. If TDH is truly dedicated to the survival of EMS both paid and volunteer then show it.
- Funding is the major problem
- Some rural services have special needs equipment to enable them to get to patients faster but most of these are considered luxury items. I think if a service can prove its need & use will cut time to getting care to a pt. it should be considered by TDH for grant money.
- Our local funding sources are not adequate to allow for the purchase of such equipment as ambulances, therefore we depend upon state and private grants to fund the purchase of such items. One of our two ambulances is nineteen years old and is in poor condition, it utilizes a one-position cot that requires at least four persons to safely load. The other ambulance is ten years old and is in fair condition.
- I would like to see an increase in the amount of grant money available, and would also like to see the dates changed on the grant process. All city and county services do their budgets in the summer to be adopted prior to October 1, it really causes problems when we apply for matching funds grants and do not know until we are in the next budget year if we received our grant. I also think the State funds these grants based on hot items or "buzz words" instead of an individual services need. I believe these grants should be funded on the needs of individual services not on the "hot new items". Its great to have brand new AED's on our units but it is silly to have them on units that are 20 years old or on units that have no certified personnel to man them.
- As much as we would like it, rural & urban EMS will never be completely equal, most of the grant monies seem to go to rural, which is where it is needed. There needs to be a greater effort to assist rural to the urban level without slighting urban.

- It was interesting that indigent care was included as a source of EMS funding in the survey. Indigent care programs administered by the counties do not reimburse EMS expense. For small EMS Communities to be progressive, that happens to be poor, as well as located in close proximity to a large, wealthy system, is a challenge at best. The public demands similar services from our EMS as they see every night on the local news stations. We want to serve our public and provide the best care that can be given as well. In fact, I have always maintained that our care must be better because our patient contact time can be as much as an hour with the long transport times.
- Current funding for EMS is NOT satisfactory. Having to depend on Medicare and Medicaid for the majority of your money is driving us & several other rural services out of business. City and county governments need to wake up to the fact of the cost of operating/maintaining/staffing EMS is growing in leaps and bounds. Maintaining “quality” people is going to cost a little more than minimum wage. Health care professionals need paid accordingly. Yes we work long hours, yes we have overtime, but last time I checked it is expensive to live and survive. Most if not all EMS personnel I know have 2 or more jobs to make ends meet. That is way wrong.
- Funding is a great concern here; education, communication equipment funding needed. Salaries are very low yet education requirements continue to rise-difficult to retain quality personnel.



MEDICAL DIRECTION

There were 6 comments relating to this area.

- Medical Directors should have more daily contact with their departments and should be required to at least attend one general meeting quarterly, so they know the people they work with.
- Since TDH wants the Medical Director to be an active part of the EMS service, make it mandatory that they attend such orientation classes. Encourage them to seek input and deliver output to TDH. No one wants a Medical Director who is purely a signature, however there are no rules requiring active participation.

Also, TDH should find some method of tracking Medical Directors who do not participate protocol, policy, or training for the service they assign their name to. TDH is good for organizing, developing, and creating committees, why not do the same with Medical Directors from each region. Listen to the concerns or ideas they may have. I firmly believe all Medical Directors would be willing to participate in a such committee. All information comes from Medical Directors that are paid to be Medical Directors full time. What about the rural physician that donates his/her time? Does TDH not think these Medical Directors have an opinion? Personally, I feel TDH is only concerned with what the Medical Director from Houston, Dallas, Austin, and other metropolitan areas have to say. What about the Medical Director in rural and frontier organizations? I would think that they have a more challenging job due to money constraints, terrain, and availability of facilities. Make the Medical Directors more active in service involvement. Offer educational opportunities to all level of providers. Rural Medical Directors should interact with rural and such. Not all Medical Directors are compensated however those Medical Directors manage to devote time, guidance, and expertise to the services they delegate practice too.

I think TDH should look at Medical Directors that have been named Medical Director of the Year and obtain input from them. Ask them what they are doing correctly and what they have learned to improve their firms and organizations. Have these Medical Directors present lectures at TDH sponsored functions. TDH should take an interest and prove that the Medical Director is just as important as the provider.

- It would be of great benefit to our organization if the Medical Director (out of town) and the local doctors would meet periodically-even once a year- to discuss differences of opinion on protocols for EMS. We sometimes get caught “in the middle” and get “chewed out” by local doctors for following our protocol. The local doctors do not seem to want EMS to treat patients as aggressively as our Medical Director expects (and we want). Also, our local docs do not read copies of protocols given to them by EMS.
- If I was a Medical Director I would have a real problem with TDH
- In small communities, it is difficult to find a medical director with the time that should be spent doing QA’s and rideouts, etc...As it happens, the director of the service and/or training officer generally write the standing orders, do the QA’s, hold inservices, etc...and the Medical Director signs off and collects a paycheck. It is easy to say, get another one. Anybody know of a physician that has an active practice that wants to work for free or for a few dollars a month and take on the responsibility of covering a number of extensions on his insurance?
- Some say leave educational objectives and control of the system to the Medical Directors. That may be good for some organizations that claim to have highly involved Medical Directors. Take Houston for example. A very devoted Medical Director, that answers to the Fire Chief! What a sterling example of quality improvement. The MD cannot get enough medics to take care of increasing burden on the system, yet a bureaucracy is in place that advocates providing “quality service.” HFD’s motto is “Seeking Opportunities to Serve.” Isn’t it ironic that they remain at critical incident management many hours a day, thus proving they are struggling to serve the identified problems without looking for more. While we mention HFD, many other systems are currently experiencing the same issues.

Medical Directors as a whole are may be as much of the problem as they are part of the solution. For example, some organizations can afford to retain MDs that are indeed interested in promoting the profession and quality of health care. This may be due to their ability to pay for that service are in some instances the gracious act of the MD to donate time to achieve personal and professional goals. To this end they are part of the solution.

Some systems enter into agreements with MDs only to find the MD is too enthusiastic and “wants medics to do too much, require too much CE, require too many drugs, or has unrealistic expectations with respect to manpower strategies.” The system dissolves its agreement with that MD, only after shopping around to find an MD to “rubber stamp” what EMS Administrators feel is “best for the service.” In this instance, the MDs may create a problem. As a stakeholder, some MDs have agreed to a minimum level of acceptance. Yet, not all MDs enter into this agreement and will “conform” to administrative desires over patient care issues. While frustrating, it is legal. Some systems look for MDs that will give them more and more autonomy in patient care while providing less and less medical oversight. Case in point, a regional service shopped for docs until they found one that would “go for anything” according to the EMS Administrator. The point with this issue is who is really calling the shots with respect to medical control.

Until the physicians can better motivate themselves or until some type of regulating group can have stronger control over doctors providing medical control for EMS, some groups will prosper and others falter. While it is overly optimistic to think that TDH could offer assistance with this issue, is it overly optimistic for the MD stakeholders to form a consensus paper regarding minimal or acceptable standards. For example, pain control in the prehospital setting. Some groups will medicate nearly anyone for nearly any reason. A Level I Trauma Surgeon in our region has complained about the trauma patient that had been medicated with at least two types of medications (narcotic and anti anxiety agent) prior to arrival, thus limiting a good much less reliable mental and physical exam.

If nothing else, ACEP, Texas' AMA, GETAC, local RACs or some group representing medical directors should issue suggested practices, based on sound science or state of the art information. Also, they should list common practices that are no longer acceptable based on best-demonstrated practice. Another Trauma surgeon recently stated that use of steroids for head injuries in the field as no scientific basis, yet several groups delivering patients to the facility where the practices routinely administers high dose steroids to closed head injuries.

It is mentioned that all designated trauma facilities should actively participate/interact with prehospital systems. A local facility has refused for years to issue any on-line medical advise or control. While it is understandable that they do not want to incur any liability, our medical director encourages us to seek input from the ER on issues not covered by our off-line medical protocols. This issue will not resolve unless outside agencies or consensus groups apply influence.



PERSONNEL

There were 7 comments relating to this area.

- The problems I see facing volunteer services in the future are keeping personnel to run the ambulance. We are losing families from our community due to economic necessity. Running the ambulance is falling on just one or two families. This means no vacation and even trips to town have to be coordinated so the ambulance is covered. Personnel is the problem and no amount of education funding, or equipment funding, or C.E.U.'s funding will place more people in our community. Does our community loose our service when those who now run it grow too old? Will our community be forced to return to the old system of throwing an injured person, a person having a heart attack, or the young woman giving birth, into a vehicle and dashing fifty miles to the nearest hospital?
- Our service is not able to provide non-emergency transport service. We have 1 crew on duty per 24 hrs, with at least one crewmember a Paramedic. Local nursing homes (2) and home health agencies wish for us to transport all patients, regardless of emergent or non-emergent needs. This issue comes up routinely every 2-3 years at least. So far, potential personnel are limited, even though our service has TDH coordinator and instructors and do offer classes. Our community is small, so interest in classes from citizens is sporadic. The addition of non-emergency service would also be dependent on tax money; of course, citizens would rather not have taxes increased to support this.
- Also, 2nd out calls so far are taken by off duty personnel, and/or volunteers (volunteers – 3 at this time). Off duty personnel responding to these calls are not paid for 2nd out calls.

- There is a shortage of EMT's (all levels) in the rural areas, and the state seems to be making it harder to become an EMT. Therefore keeping rural areas shorthanded.
- At this time we are having difficulty maintaining 24hr coverage due to lack of volunteers. We had a meeting to inform the townspeople. We had 12 people sign-up for an ECA class, but I don't know how dedicated they will be or if they will conform to Education like ECA classes, CE classes or checking out the trucks. There is an area 11 miles away that is in the same position. We would like to consolidate others in our area to help cut down on the amt of paperwork required by each service but we are running up against the political walls. We do not mind all the educational red tape, but all the paperwork required for retraining seems a little much. I have a full time job, family, & attend school but I still had to find time to do all the paperwork.
- I feel that we are not doing enough to encourage people to volunteer in the rural communities. We beg for volunteers and then tell them they must drive 60 miles 2 times a week for class, and then they must pay for it out of their own pocket. Then they are treated as second-class citizens because they are not paramedics. We wonder why our volunteer resources are drying up?
- All of us have full time jobs and work outside of the City. Everybody else who works for us has a full time job and take call for our service when they can. In today's society it is becoming increasingly difficult to recruit, train, and keep qualified personnel



RAC ISSUES

There were 11 comments relating to this area.

- It seems that the Goal of the RAC is to be punitive, and not for services that are not providing a good level of care. It is punitive to services that "don't attend RAC Meeting's" or "don't submit report's". These items are too time intensive for small volunteer services to meet. One "2 hour" RAC Meeting will cost our service one man for six hours. (We have a 140 mile drive to the meeting to start with). Each report to transmit takes about 30 minutes. Unfortunately, almost all of our personnel have full-time jobs...we do not have time to do unnecessary meetings. (I feel guilty about assigning others to do this unnecessary work)

Maybe I am "missing the boat", but I have no earthly idea what the RAC System is trying to accomplish, that our area was not doing anyway.

- Small volunteer EMS groups have a hard enough time staffing trucks to make calls. All we need is another form or report to fill out. Regarding the RAC requirements, it is nearly impossible for small services to make a mid afternoon RAC meeting 80 miles away. We are volunteers. Come out in the sticks and see what real EMS is about.

- This is not a problem with TDH but it needs to be considered in my opinion. The RAC has guidelines to keep in good standing making the meetings that are required are very difficult for vol's due to someone loses pay from there regular jobs that are not related to EMS. This topic has been brought up with the RAC but no headway has been made.
- The funding received thru RAC monies is extremely beneficial in keeping equipment that is up-to-date and operational. The equipment purchased and distributed by the RAC is very welcome, as well; monies to help fund classes help to keep our personnel trained.
- It has been difficult for our RAC to determine how to best spend monies available from state and tobacco funding although it has provided several items that were needed by us for patient care. The RAC needs to come up with a method to more effectively utilize these funds.
- I feel TDH steps over boundaries and try to have too much control. . I have a major concern about the way I feel TDH wants to run our RAC. We have a few (maybe 1 or 2) individuals that want to represent 2 or 3 entities. Several of us feel this should not be allowed because that 1 person representing more than 1 entity can't do the work of 2 people. Every representative should take responsibilities within the RAC to make it successful—Not just stand there with their hands out for money & any thing else they can get their hands on for free!! When we had a couple of our RAC members go to Kathy Perkins (and only God knows who else) that our RAC was not user friendly really made several of us mad because the next thing we heard was how RACs need to be user friendly or TDH would step in and set the guidelines. TDH needs to have us alone & let us run our own RAC.
- I have had the privilege to assist with the development of our RAC and I know we have the people and the other resources in our region and state to accomplish great things in all areas of prehospital care. In my opinion it is time to get on with it.
- My only concern now is that the RAC seems to keep adding responsibilities to the services in order to qualify for RAC monies.
- We feel that requiring a service to participate in RAC activities and to have this tied to your provider license is unfair. This is extremely time consuming for what you get in return.
- We have been a member of our local RAC for five years. I thought the original purpose of the Trauma system was to improve the care provided to trauma patients. I also thought the RAC was intended to help rural providers. We remain active in our local RAC out of necessity rather than as a means to improve our trauma care. It has been our experience that the RAC is also geared to large metropolitan providers. I say this because we have to commute seventy five miles or more one way, to attend the meetings, and in my opinion the discussions and policies are not beneficial to our organization. Our RAC just hired an Executive Director at a salary of eighty five thousand dollars per year, yet they were not able to supply us with a computer to comply with the new reporting requirements effective January 1st 2002. The Executive Director's salary is more than my entire yearly budget.
- RAC Participation: Small services with minimum employees have great difficulty in having employees free for meetings. One person should be able to attend on behalf of more than one service.



RULES AND CONSTANT CHANGES

There were 16 comments relating to this area.

- We are extremely concerned with the changes, constant changes, in EMS. Progression is a good thing but we, as a whole, need to figure out what we are going to do and do it. It is getting increasingly more difficult to know what we are to do as providers and what to tell our employees about certification. Project Alpha started off as a good thing and ended up, a joke
- There is a shortage of EMT's (all levels) in the rural areas, and the state seems to be making it harder to become an EMT. Therefore keeping rural areas shorthanded.
- Things should be made more simple in all areas of our work. But here lately they only want more and more paper work. We as E.M.S. personnel have a lot to cope with out in the field. Then it seems that the government & T.D.H. are trying to bury us in nonessential paper work. We are all just trying to do the best job we can but are hitting dead ends all the way around.
- I think TDH overacts on minor issues and is afraid to act on major issues. Yes, I know TDH is not really the end of all of "EMS Police", however when a highly controversial issues supported by TDH representatives, firm Medical Directors, and firm Administrators, TDH needs to "wake up" and look into that situation. If there is such great concern from all the patients involved, then there is something wrong.
- Regional councils should be set up and each case reviewed without prejudice before being taken to the State Review Board. These councils should consist of Medical Directors, Administrators, and street medics. Along with TDH Representative, should they feel the issue is not worth pursuing then the complaint is found not valid and no action is taken. Should the council feel that they matter should be presented to the Review Board then it shall be so. Assist them in researching the private provider and offer statistics of private provider failure, before the community becomes a victim of that service. This will prevent the community from leaving to rush out and create another entity in order to "pick up" from the private provider
- I realize that there are rules & regulations in place, it just seems that it is aimed at larger paid departments. I realize there is danger in having a double standard, I'm trying not to say it that way. But we (vols) have a very difficult time in meeting the same rules and regulations. I know we are a small percent of the EMS system, but I believe we are vital for Texas EMS.
- I was one who was all for the licensed paramedic. How we got there was a sham! Yes we need to increase our educational requirements but as soon as anyone is educated they are then to smart to stay in EMS. First we need to keep the nurses, and other special interest groups out of the regulation of EMS in this state. They have no say so. How many paramedics or EMS reps are on any nursing boards or regulatory agencies? If we continue to raise educational requirements, it must be phased in with funding and support, and then lead to higher waged for EMS personnel.

- TDH policies vary greatly from region to region. There must be some form of standardizing the regions. I think there has been progress but still needs to be done to make the transition from region to region seamless.
- I think each provider agency should be supplied with a printed book of TDH policies & regulations (not something that has to be downloaded).
- It is my opinion that TDH makes rules and regulations based on larger providers and small providers like us have trouble trying to comply
- Interesting!!! (Everything evolves as a general rule). What comes around seems to come around again if you stay in it long enough!
- The best one yet is the rule that in order to become a Licensed Paramedic, your Bachelor's degree has to be from a regionally accredited university as opposed to a nationally accredited university.
- It appears to some of us that EMS is the "bastard stepchild". We need to do to identify the reason we stereotyped and correct it. However, it appears that during the past decade, we are our own worst enemy. We hastily conceive a plan, debate it for years, get a consensus vote, stir the ire of the special interest groups, revisit the issue, debate it again, and on and on for years, get the issue into rule, law and then second guess it to death or simply BITCH about how poorly it was thought out. Evidence of this process can be found in: EMS CE, Recertification process, Licensed Paramedic issues, climate control for drugs (our local supplier houses them in an unconditioned warehouse several days at a time and they are delivered by UPS's climate controlled brown van.) governing boards that are not liked being dumped, renamed and the process starts all over again. While the above process is in full swing, TDH suffers more cutbacks, loses talent to other industries and in general appears to be suffering.

Mrs. Perkins and Mr. Arnold even mentioned how intricately woven many of our governing documents are in other rules. They admit it is complicated. Think how lost our average certified person gets while attempting to sort through the layers of bureaucratic tape. Making things even more difficult is the fact that you can call one region and get its position on an issue, can another get a different answer and then post to an e-group to find out the multiple people have been told multiple things by multiple agency reps or possess letters from TDH that contradict themselves.

EMS's overall lobbying efforts in general are abysmal. With the exception of some stronger (fiscally and politically) who generally get their point made by a politician, most EMS issues are at best grassroots level and go nowhere.

GETRAC attendance is sporadic. People in our region see no benefit of making the meetings. Frontier folk complain about the trip and expense versus benefit. With the technology available everyone has input. Yet TDH reports little input about various issues. The same Technology could offer webcast of the meetings, with input by e-group messaging.

This whole process needs more well thought out input by everyone. Again, CE programs designed to heightened awareness of this process should be offered. Everyone has an opportunity to be heard and/or adequately represented but many do not know who to access such avenues

- Overall we have no problem with either the policies or then administration. The one area where we are encountering a problem is that we, a Volunteer organization, have found it necessary to hire paid personnel at the paramedic level. This is primarily the result of the increased requirements to attain the paramedic certification. As the training programs are now being administered it is nearly impossible for a person holding a non-EMS full time job to meet the training and clinical rotation requirements.
- I feel that we are making it hard on volunteers to achieve and maintain EMT certification



TRAINING

There were 21 comments relating to this area.

- With the Colleges going to completely degree programs and not offering a Certificate program is killing the hiring pool.
- There should be more free training to EMS and fire personnel as to the required standards they must keep up with. Re certifying should not be so hard to do. TDH should send out reminders for re- cert and testing areas should be more convenient and have more dates. Clinics should include more field training on the Med Units and less in hospital. In my opinion the hospital training is limited and most of the time the hospital personnel act as if we are a bother or burden to them. Roles, responsibilities, medical legal, and documentation should be more widely addressed in the initial education process. So many medics seem to not know how to document and don't realize the importance in complete documentation, to include; pertinent negatives, MOI, documenting delays in response times and why, not just, they provided wound care but with what and how, etc: These are just a few things that one EMT feels very strongly about. Thank You
- My main disgust or problem is with the new rules for certification of advanced providers, or paramedics. We now have a limited system of paramedics due to having to route their education through our local university. While I do realize the importance of education & the need to increase our professional appearance & knowledge, I find our area without choices or resources to advance education. I was last told by our local college education provider that it would take more than 2 years to have our intermediates advance to paramedics. This is a complete loss for our service. Why would our intermediates want to endure this time & effort to advance their pay to minimal increases? Now, I do see many who would endure the time & effort just to increase their knowledge & education, but at the same time, it would limit their work time, income, family time, & their abilities to provide care for the rural areas. I know this is a problem that cannot be solved overnight, but I believe there are solutions. Once again, I wish to express my concern for increased education, but I feel the State went about it the wrong way. Thanks.
- The State test questions should come from the book that they are taught out of. The way State places questions are very confusing and some don't even apply to what was taught to students. We as Instructors are have great difficulty in trying to teach our students because they have a problem understanding T.D.H. State questions.

- Also there should be a more simple way to retest our medics. Such as after 10 yr's of service the medics should only have to have C.E. hours to resort. Because of in the field training and level of experience.
- Remove the requirement for training programs at advance level where the coordinator needs a degree and the program has to be attached to a leading college. Remove the National Regents Exam. Lower the paramedic training hours back to 400.
- TDH should take an active role in training the rural/frontier provider and that providers Medical Directors. TDH should hold or sponsor protocol development classes, policy/procedure classes. Medical Director classes, educate the smaller provider that cannot afford to have a full time paid person dedicated to protocol development.
- TDH should also sponsor classes for the EMS Administrators or Directors. Give them guidance and opportunities to speak out on their feelings of TDH's role in governing and participation of local programs
- Pt. care should be the 1# focus, this places education and communications as priorities.
- I think TDH should do away with instructor state test as long as a person takes a course on instruction & passes that course that should be all that's required. I know several people who could not pass TDH test but pass instructor class with no prob. And are very strong teachers this would help rural EMS to have in house ECA/EMT/EMTI & EMTP. Classes & ER programs
- Education-it sometimes hard for rural/vol. agencies to gain classes due to class size and location in areas.
- If money is available to be used for college classes to upgrade paramedic certifications to licensure for those interested, that benefit will make the difference for some people who cannot afford to pay individually.
- It is forty miles to the nearest Junior College where we can drive to educate our personnel. We feel that a jump from 80 hours to 190 plus for EMT-I class is very harmful to our future. It is difficult to ask a volunteer to spend that much time and money to receive the same training. The cost to our organization had more than doubled for tuition and books. The same is equally true for the EMT-P class. We do not believe that the "NEW CRITERIA" is an improvement over tried and true information. We realize that because of our long transport time we must be more effective than many other EMS units. We feel that it would be more appropriate to spend your energy improving the quality of instructors in Texas.
- We desperately need to increase our staff of certified volunteer EMT's and to advance the certification level of existing EMT's by conducting classes within our area.
- We need better training for ambulance drivers; often times we utilize drivers who have had little or no training and have never even ridden out on an ambulance. Most of our non-certified drivers are over sixty-five years of age.
- We utilize Sheriff's Office Dispatchers most of which have no knowledge of CPR or other life saving procedures.

- By requiring initial training courses to be college based TDH has created a situation where new recruits will have to commute sixty five miles one way to attend training courses. In the past we have provided free initial training courses to people interested in helping out in our community. This is no longer an option. People cannot afford to pay six hundred dollars for initial training, and spend three or four months commuting sixty five miles one way to class.
- The practice of EMS is indeed evolving. Many organizations are boasting about the vast number of drugs they are carrying (RSI cocktails, narcotic analgesics, thrombolytics, glucocorticoid steroids, and others), the highly technical skills they allow their medics to perform (Rapid Sequence Intubations, Doppler capability, cardiac sticks, chest tube placement, and surgical airways), and the high quality of care they provide. We as an industry in Texas boast about our capability, however, it appears that we have not been as enthusiastic about preparing present and future medics for their jobs. The recent decision to accept EMT-P standard for education competencies and testing is admittedly amusing. I will never agree that a medic with some 600 hours is as well educated as one with 1200 hours. Hearing the debate and listening to side bar discussions, it was clear to some of us that the Fire Service obviously exerting its weight. The cry seems to be more of fiscal pain than desire to promote the EMS profession. (The same profession that has been usurped by them to promote the fire department's image and career path.) Despite what was said, you cannot expect some students to be able to "get the information" on their own. Even more amusing is the recent turn of events that will require TDH using the National Registry Exam for certification. I cannot imagine any administrator or educator who would willingly allow an employee or student to sit for an exam only half prepared by a sound educational process and half prepared by "self motivation to get the rest of his/her own."

While the issue of training "seems" to be settled, some of us are concerned that if we cannot place paramedic education in institutions of higher learning, we are facing new problems. One such problem is a medic with limited education will be used to teach, mentor and precept new medics. This will in essence help "dummy down" paramedics. Then what will be the basis of our braggadocious chest banging and gregarious chants about quality?

Colleges are increasingly having problems meeting minimum student requirements to hold a paramedic class. Despite creative scheduling (days, nights, weekends, internet classes and one-on-one instructor sessions) enrollment is reportedly declining at colleges. However, in Region 5/6, I frequently receive information about "quick and easy paramedic and other EMS related courses tailored to meet your needs." On investigation, some of the instructors appear less than qualified to actually instruct the course. (I do not consider an instructor to be qualified based solely on the fact that he or she is a paramedic.)

During one of the Education Committee meetings, a person speaking for the fire service stated in house programs or programs tailored to the department's needs are preferable over a college program. That person went on to state that way it could be tailored to that department's medical director and specific protocol. I feel this myopic attitude is further propagating the "dummy down" education process. While it may be good for the department, it leads to regional isolation for the student and potential employment problems for the medic in the future.

- A full time medic recently told a student he was precepting that it smarter to spend two years in nursing school than to spend almost as much time to become a paramedic. He based his statement on the fact that many programs take almost two years to become a medic and graduate with an AA. Additionally, he points out that many medics make significantly less than a registered nurse. His remedy for that was to go to a bridge program and become a nurse rather than compete for positions a regular nursing school. This process will ultimately hurt nursing as medics as nurses do not have the same skill set and/or thought process as a nurse that went through nursing school. Additionally, not many medic/nurses practice in non-urgent care settings which further compounds the nursing shortage. Further medics that bridge typically do not stay in the prehospital work force.
- I have been a State Certified Paramedic and a Licensed RN in Texas. I can tell you that the Paramedic exam makes Nursing Boards look like a Red Cross First Aid Test.
- I do not agree with the process of re-certifying in Texas as an EMT. There are too many CE Hours required. The nursing license requires 20 hours every 2 years. I know that we lose many EMT's because of the current CE requirements.



WAGES

There were 10 comments relating to this area.

- Why would someone go to Paramedic School at the length it is now to make low wages. In larger cities the pay is going up but it is not in smaller cities. It will take a lot longer to get pay up in rural areas
- The greatest concern for our service includes maintaining high quality employees with the ability to pay them what they deserve.
- Too often, experience does not come in to play when an employee moves from one company to another. You get to start back at the bottom, again.
- I believe that EMS wages are very low and this needs to be addressed. Our respective butts are on the line out there and in not so convenient conditions. We should not have to work so much overtime just to make ends meet.
- Pay Scales: We struggle to pay experienced paramedics 23,000/yr – payroll with minimum benefits is 2/3 of our budget

- The current pay scales for medics may be a contributing factor in the manpower shortage issue. Several agencies in the Gulf Coast area are complaining about serious manpower issues. Yet they maintain pay scales that are substandard to other professions including checkers at large grocery store chains. Recent discussions with an administrator found that his overtime pay to cover vacancies lead to attrition (burn out) while enhancing the annual pay for regular employees. Calculations offered by this administrator, proved he could significantly increase base pay and step pay for all and may even limit the need for overtime by making employment opportunities with the service attractive. This myopia is probably due to the fact that the manager “worked his way through the ranks” and maintains his position based on politics rather than competencies. Yet, he as other administrators are partially charged with advancing our profession!
- We all look at the JEMS wage survey and laugh. The few “high” wages are the exceptions and not the rule. Expanded scope and higher education are good starts to improving wages, but mandated service requirements will force citizens to pay for what they want
- Several ESDs in the state have boasted about the amount of new equipment, the number of fancy paint designs on that equipment, the amount in the checking account and the monies they can foreseeably bring in over the next budget year. Yet these same groups have medics that are leaving because of poor pay, poor benefits and lack of support by their superiors and boards. Some of these boards and administrators are complaining about the attrition, poor employee performance and employees abusing equipment. They never realize the custom artwork on their vehicles is easily three or more month’s salary or more for even some of their finest employees.
- Current funding for EMS is NOT satisfactory. Having to depend on Medicare and Medicaid for the majority of your money is driving us & several other rural services out of business. City and county governments need to wake up to the fact of the cost of operating/maintaining/staffing EMS is growing in leaps and bounds. Maintaining “quality” people is going to cost a little more than minimum wage. Health care professionals need paid accordingly. Yes we work long hours, yes we have overtime, but last time I checked it is expensive to live and survive. Most if not all EMS personel I know have 2 or more jobs to make ends meet. That is way wrong.



RURAL ISSUES

There were 13 comments relating to this area.

The comments in this section are also found in other areas of this document. They have been placed in this section to concentrate all comments pertaining to Rural and/or Frontier EMS issues.

- Give to the rural services, that are really trying to make it. I’m not asking for 100% funding, but distributing money to assist in training, community involvement programs, computers, and capital equipment procurement. I know there is the Grant Program put on by TDH, however categorize services into groups according to size. Then distribute the money accordingly. I do not think larger tax supported entities should be eligible for the same amount of money. If TDH is truly dedicated to the survival of EMS both paid and volunteer then show it.

- Some rural services have special needs equipment to enable them to get to patients faster but most of these are considered luxury items. I think if a service can prove its need & use will cut to getting care to a pt. it should be considered by TDH for grant money.
- We are an all-volunteer emergency medical service serving a large frontier area. We do not have a functioning fire department in our area to aid in assisting with loading patients or extrication of patients from vehicles. Extrication equipment and crews must come from outside the area resulting in long scene times.
- As much as we would like it, rural & urban EMS will never be completely equal, most of the grant monies seem to go to rural, which is where it is needed. There needs to be a greater effort to assist rural to the urban level without slighting urban.
- Current funding for EMS is NOT satisfactory. Having to depend on Medicare and Medicaid for the majority of your money is driving us & several other rural services out of business. City and county governments need to wake up to the fact of the cost of operating/maintaining/staffing EMS is growing in leaps and bounds. Maintaining “quality” people is going to cost a little more than minimum wage. Health care professionals need paid accordingly. Yes we work long hours, yes we have overtime, but last time I checked it is expensive to live and survive. Most if not all EMS personnel I know have 2 or more jobs to make ends meet. That is way wrong.
- In small communities, it is difficult to find a medical director with the time that should be spent doing QA’s and rideouts, etc...As it happens, the director of the service and/or training officer generally write the standing orders, do the QA’s, hold inservices, etc...and the Medical Director signs off and collects a paycheck. It is easy to say, get another one. Anybody know of a physician that has an active practice that wants to work for free or for a few dollars a month and take on the responsibility of covering a number of extensions on his insurance?
- The problems I see facing volunteer services in the future are keeping personnel to run the ambulance. We are losing families from our community due to economic necessity. Running the ambulance is falling on just one or two families. This means no vacation and even trips to town have to be coordinated so the ambulance is covered. Personnel is the problem and no amount of education funding, or equipment funding, or C.E.U.’s funding will place more people in our community. Does our community lose our service when those who now run it grow too old? Will our community be forced to return to the old system of throwing an injured person, a person having a heart attack, or the young woman giving birth, into a vehicle and dashing fifty miles to the nearest hospital?
- There is a shortage of EMT’s (all levels) in the rural areas, and the state seems to be making it harder to become an EMT. Therefore keeping rural areas shorthanded.
- I feel that we are not doing enough to encourage people to volunteer in the rural communities. We beg for volunteers and then tell them they must drive 60 miles 2 times a week for class, and then they must pay for it out of their own pocket. Then they are treated as second-class citizens because they are not paramedics. We wonder why our volunteer resources are drying up

- It seems that the Goal of the RAC is to be punitive, and not for services that are not providing a good level of care. It is punitive to services that “don’t attend RAC Meeting’s” or “don’t submit report’s”. These items are too time intensive for small volunteer services to meet. One “2 hour” RAC Meeting will cost our service one man for six hours. (We have a 140 mile drive to the meeting to start with). Each report to transmit takes about 30 minutes. Unfortunately, almost all of our personnel have full-time jobs...we do not have time to do unnecessary meetings. (I feel guilty about assigning others to do this unnecessary work) Maybe I am “missing the boat”, but I have no earthly idea what the RAC System is trying to accomplish, that our area was not doing anyway.
- Small volunteer EMS groups have a hard enough time staffing trucks to make calls. All we need is another form or report to fill out. Regarding the RAC requirements, it is nearly impossible for small services to make a mid afternoon RAC meeting 80 miles away. We are volunteers. Come out in the sticks and see what real EMS is about.
- TDH should take an active role in training the rural/frontier provider and that providers Medical Directors. TDH should hold or sponsor protocol development classes, policy/procedure classes. Medical Director classes, educate the smaller provider that cannot afford to have a full time paid person dedicated to protocol development.
- Education-it sometimes hard for rural/vol. agencies to gain classes due to class size and location in areas



MISCELANEOUS

There were 35 comments relating to this area.

- TDH and the state of Texas need to find a way to provide perpetual ambulance service to every person in the State. People need to feel the security in knowing the ambulance service will always be there as they now have law enforcement and fire protection. The closing of small town hospitals have caused citizens to look to the ambulance service to provide fundamental/advanced medical care in their community. An ambulance service in a rural/frontier area today is the “doctor making a house-call” in the past. A Statewide system is going to take new thinking to make this possible. Funding this system will be the greatest challenge. Could a system be funded by a state wide sales tax that included everything even farm commodities, feedlot cattle, stocks or bonds purchased or sold, insurance policies, health plans, etc. and etc.

- Which current ambulance services would then be funded. Would a new placement system have to be implemented? Someone would have to determine what the maximum length of time for an ambulance response should be, to determine the placement of ambulances. Would it be morally reasonable to tell people they will have to wait thirty or forty minutes for an ambulance to arrive? Does this mean that a person who chooses certain occupations or to live in a certain area is also choosing to deny his family a reasonable ambulance response time? With unacceptable response times would this then mean that everyone in Texas needs to be trained as first responders, with AED's in every community or home? Would the State and TDH support a program whereby a member of a frontier family would be trained in advanced life skills and then allowed to stock at home cardiac drugs and narcotics as well as an AED all provided by the State to be used until an ambulance or helicopter arrives? Is all this just wishful thinking? Will we wait and let people die because of where they live? Is this a fact of life that cannot be overcome because it costs too much? The state of Texas will have to declare war on unnecessary deaths to put forth the effort to reach a solution to this problem.
- Of the twelve certified people with our service (paid and volunteer) nine are paramedics. We feel that our community is fortunate to have the level of service that they have. We are very self sufficient, providing as much of our own C.E. education as possible. Additional education is paid mostly out of our own pockets. However, our county officials have been very supportive of our service, and have ensured that our operating expenses will be paid, one way or another. So far (since 1995) the service has pretty much supported itself.
- With all the monetary needs in the state of Texas regarding trauma (ie. Prevention programs, education, care of the injured patient, equipment, uncompensated trauma care, etc.) it seems that a great deal of money is spent inappropriately. For example – It is my understanding that TDH contracted with a firm to design and develop a trauma registry database for the state of Texas along with a web based data entry system that would be available to all RACs for a cost around 2.1 million dollars. Target date for completion would be around the end of 2001.

It is also my understanding that TxDOT appropriated approx 2.7 million dollars to the RACs for the specific purpose of purchasing hardware and software to facilitate data entry into a state and regional database. The TxDOT money had to be spent specifically as directed and in a certain time frame or the RACs would lose it.

The RACs were not about to give back the money so they proceeded to buy trauma registry software, desktop systems and palm pilots with the necessary software to make them functional. Just buying stuff whether needed or not to keep from sending money back.

Many EMS services in our RAC will have purchased for them a palm pilot and the necessary software to go with it even they only average 1-2 runs a day – Hardly a need there or a wise investment of money that could have been spent on some of the items I mentioned in the first paragraph! I'm sure that the purchased trauma registry software will probably be nice but was all that money spent wisely if TDH was already developing a web based data entry system?

Perhaps if there had been a little communication between these two large governmental agencies they could have worked together for a common good and there would have been a lot more money spent in areas that would benefit the injured patient.

- A five year EMT, has more on a 6 month LP any day, Higher Certificate or not. Of course that changes in time

- EMS personnel need to be taught we are public servants not “ParaGods” Attitudes of some large town “professionals” are not good for public relations. Suggest some cities EMS’ need to adopt smaller town EMS’ to help keep up their skills, because they have the lower call volume. Trauma funds & tobacco funds need to be given directly to EMS services to use. Not to go thru city/county judges-(some of them put \$ in accounts & never let EMS have say of spending it)
- TDH is killing the small providers that are barely keeping their heads above water.
- The solution from TDH is always “hire someone”, not all providers can afford that. What if TDH took a proactive stance, and asked the provider, “where can we help you?”
- I love being a Paramedic, it is one of the most regarding jobs, however, having to “wheel and deal” for my staff and firm is not one of my favorite tasks. I know TDH’s intention is good and 80% of the time our Representatives are more than helpful. I appreciate their efforts and guidance, but as with any organization there is room for improvement.
- We have a very good system in place but I think one future as EMS providers and Leaders must be focused on additional personal and equipment to provide adequate services for the people of our state. Our population is rapidly outgrowing our service capability on a day to day basis. Mutual Response is an absolute necessity but one must have the equipment and personel to respond.
- Sometimes vol. agencies get the feeling that TDH is trying to make it so hard to keep current. It is completely impossible to have enough education and monies to keep up. There are a lot of difficult times for vol. agencies . I realize that there is a lot of funding available to EMS agencies, but trying to get grants is a tough job for vol’s. I know in my region there are EMS agencies that do not participate in the RAC, but need funding and that’s not going to happen with the current laws.
- The 911 system in Texas has for many years had a surplus of money. In the sparsely populated counties in West Texas that we serve 911 is a disaster of ineffective communication. This could be solved by using a tiny part of the surplus to update and modernize the equipment in West Texas frontier counties.
- First let us proclaim that there is no apparent organized effort from TDH BEM to make a plan for sustaining EMS in the state. Period, no further explanation needed there. We believe that until the avenues for direction. How many times on the list-server have we all complained that Fire suppression in Texas is given more concern and mandates than EMS. Why have we put property over life? Cities, and towns must be required to have some form of required levels of EMS that they have to provide. If left to each community to decide how much EMS they want, then they will always get the lowest bidder, cheapest form, no quality control systems available. Just as police protection is required in communities so should ALS-MICU ambulance be required. This should be our goal, how we get here will take more then our ideas! Funding is there if we can keep it going to EMS and not special interest groups. Like the 911 surcharge on our phone bills, why isn’t that being used to fund EMS. How about a mandatory fee on auto registration. These have been presented in the past but because we don’t have our act together in Austin they fall time, after time after time when it goes to the floor.
- I was one who was all for the licensed paramedic. How we got there was a sham! Yes we need to increase our educational requirements but as soon as anyone is educated they are then to smart to stay in EMS. First we need to keep the nurses, and other special interest groups out of the regulation of EMS in this state. They have no say so. How many paramedics or EMS reps are on any nursing boards or regulatory agencies? If we continue to raise educational requirements, it must be phased in with funding and support, and then lead to higher waged for EMS personnel.

- GETAC membership should be rotated on an annual basis to allow at least 1 member from a provider from EACH county in Texas an opportunity to serve on this important committee. This could be a sub-committee. After 1 year of sub-committee service they should either step down or be moved up to the main committee
- Most of our volunteers work either outside of the service area or full-time jobs within the area and are not available for ambulance duty much of the time. Also we need additional equipment such as AED's; currently we only have one unit in our entire service area.
- I do not believe a Licensed Paramedic is any better than a Certified Paramedic. Field experience and common sense means a lot more to me. I have a real problem with having the word Licensed crammed down my throat!!
- In regard to compensation for the different levels, I feel that the salaries for these levels of certification should depend on the service they work for. If an individual is just answering calls is one thing, but if that individual is answering calls, doing billing, training, maintenance, or other duties then that person should be compensated more.
- I do feel that compensation should increase with the level of certification, but I do not feel that a Licensed Paramedic should be compensated more than a certified Paramedic just because of their licensure status. If these individuals are in a management situation then compensate them for that, not the level of their certification or licensure. I personally have a degree and am a Licensed Paramedic, but I would rather have a certified paramedic with experience running my service than an individual with all the education in the world and no experience
- I also think that we are not doing a great percentage of our population justice, we have spent the past 15yrs developing a trauma system, I think this is great but we have almost completely forgotten the other 90% of the patients we deal with. I realize that trauma cost a lot of money, but in our area major trauma only amounts to about 10% of our call volume. We have rode this horse, let's move on to something else. If we invested the amount of time into diabetes, cardiac problems, respiratory problems, or other medical emergencies that we have on trauma in the past 15 years think of where we could be. Lets think for a minute of the number of people out there who are disabled due to diabetes, cardiac disease, stroke, or other diseases. These conditions may not be as much "fun" as the blood and guts of trauma, but they are just as costly to a family or a community.
- I think response areas should be in regards to time not line and this should be reflected in the 911 center and mandated by the State.
- I think TDH should set up guidelines for pay rates for each level and set a standard. I also think EMS (who may not be fire dept based) be recognized as the fire depts. Are regarding retirement and death benefits.
- I have spoke with several EMS people in communities the same size as mine and we all share the same concerns. We need more qualified EMS personnel. We need affordable local training. We need fewer restrictions, and regulations. We need more money to operate our service. Our cities are experiencing budget shortfalls citywide and we need access to more grant funds just to keep our services operating.

- Unfortunately everything is relevant (to hrs worked-type of system etc) while all of us are heroes in our daily jobs- In light of the publicity & heroism of our fellow workers in New York City – we should make the salary of a professional sports player or entertainer.
- Every ER should appoint a hospital –EMS liaison. The larger the hospital, the ruder the nurses. It should be mandatory for all ER nurses to spend time on a truck just as EMS personnel must gain experience in ER during their clinical internship. (I have been both, an ER nurse and a field medic).
- I think that we should have to join one more organization and be on one more committee! In a smaller EMS, the director does everything and time is a commodity. It is difficult to make the GETAC, the RAC, etc...even when the meetings are monthly. We can barely keep our head above water yet all of this is tied to extra funding, the very thing we do need..
- Response and Logistics: Dispatch is a big problem for small services, especially when counties start requiring computer time stamps. Funding for communications is a luxury when you are struggling to keep an ambulance staffed and supplied. Also inhibiting retention within the profession is the inability to move from system to system without starting completely over. Few systems offer incentives for longevity in the profession, college credits, advanced training or specialized training. Even fewer systems have programs that encourage advancement. Due to this, there is a grass roots level from certain state holders to create a commission to help advance our profession. If it is like other commission boards within the state, it will only add more bureaucracy, more dues and more personal sacrifices for the many to benefit the few.

The issue of equipment is also important. Single use (expendable items) offers an insight to the need for Texas Agencies to unify. Larger systems with larger budgets typically get better purchase prices. Unfortunately, smaller systems with smaller budgets (typically) pay more for the same items due to limited purchase power. Yes, Texas does have a purchasing cooperative. However, the last time I checked, I could purchase nearly all items by EMS cheaper from a general vendor than I could from the State. RACs should be encouraged to united and increase prehospital agencies' purchasing power. HGAC is another example of a good thing that may not be so good. Recent purchases in our area proved that by collectively (yet individually) combining numbers, our prices were lower than the “government contract” and in quantities that are dictated by the department, not the bureaucracy.

Next, is the concern that collectively, prehospital systems, private practitioners, hospitals and governmental entities are not collaborating to educate the public about access to health care. It may take an “act of Congress” to encourage this collaboration. However, all parties must actively participate in educating the public as to appropriate methods to access the health care system. Many want to focus on the indigent and lower socioeconomic groups as the target group as the primary culprits of the problems of the system overcrowding. However, when a governing body spends more on improving professional sports than on indigent health care, it is easy to see that all people need educated.

A clear example that all persons need educated regarding the expense of healthcare and need to supplement health care is that of the drug trafficking laws. Local agencies collaborate in a drug bust, real properties, assess and monies can be used by those agencies to further the advancement of the Drug Task force. None of the monies are used to compensate the cost of the medical cost generated by either the drug users or those injured by him/her. Yes the Victims assistant program is available, but probably under funded and under utilized. Part of the monies set aside to combat drug trafficking should be earmarked for use in treating victims generated by that “industry”. The person(s) needing educated in this example include all levels of politicians, and eligible voters.

There is a nursing shortage in the state. Some facilities are shoring up their manpower with EMS providers. Does this process create a shortage in EMS? Also, we do not hear the same rebellion from THA, or other groups when EMS professionals are hired to work in hospitals or clinics. Yet when nurses attempt to help out in EMS, we legislate against them, require additional training and certification, and in short find every conceivable effort to halt this process. All the while crying that EMS is suffering incredible manpower shortages. Further, colleges have responded to manpower issues by developing bridge programs for paramedic to nursing, and EMS is complaining that its not fair for nurses to challenge the course and even suggest nurses take the entire curriculum.

Realistically, nurses will probably not seek EMS jobs but rather help-out especially in rural and frontier areas. Why not simply change the law and allow nurses to ride as part of the crew and not mandate two certified EMS professionals. The same goes for fixed wing and rotor-wing aircraft manpower requirements. The aircraft problem was not a problem until some well wisher fixed it to protect whom.

During GETAC and various RAC meetings, low pay has been cited as the main culprit for attrition in EMS. Ironically, it is often system administrators making this statement. Studies have already shown that while important, money is not the major reason people enter a profession or leave. With respect to job satisfaction, money is not even in the top two or three issues cited. Many agencies have created their own problems by not paying required overtime, generating oppressive work schedules that have no good basis, making unusual demands on employee's off duty requirements (Carry and pager and come in when we call. Do not expect compensation for carrying the pager. Expect to be punished for not coming in no matter what other personal conflicts you are experiencing.) and managing by management methods that have not been accepted in the business world for 15 or 20 years. We need to focus on the problem, not the results of the problem.

EMS in Texas has come a long way. However, despite what some may think, you cannot legislate a particular workforce into professionalism. Dress codes, collar brass, paramilitary rank structures, voluminous SOP's with lots of shall and shall not italicized and bolded, the see one, do one, teach one educational process, and an avalanche of legislative mandates will not advance EMS any further. Self-centered special interest groups have set us back years. Petty grievances and bickering on the Internet chat groups is rampant. Attempting to demean other professions (nursing and allied health and even beauticians) while beating our own drum is not constructive.

EMS's plight with regard to seeking professional status is mirroring that of nursing. In the 70's, 80's, and early 90's nurses were seeking status for their profession. As they became less fragmented, more educated, began more research, lobbied and proved themselves as a unified group, the professional evolved. NANDA's nursing diagnostic categories, in many people's opinion, was the gateway to establishing nursing as a profession. However, the cornerstone of the profession still remains, sound education (based on achieving measurable competencies combined with valid and reliable testing.)

We cannot blame city fathers for not increasing pay for people who continue to decrease the requirements for minimum entry into our profession. We can no longer bemoan communities for not increasing our pay when we are perceived as doing little more than transport patients. We must attempt to grow our profession with community service, immunization clinics, public education, sound practices, personal development, education based on measurable outcomes and attention to research or at least best-demonstrated practices.

Rural and frontier designations for services have generated considerable interest. The terms seem to be the banner leading legislative cries and peaking interest. Yes, we need to do something for these areas to improve the quality of care available. However, in our zealous efforts to promote care in these areas, some of us stand in awe of the lack of parity of care in metropolitan and urban areas. True some services in Texas have a 30 plus minute response to a hospital. However, in the Gulf Coast Area, while our transport times are shorter, if we honored ever drive-by request, we too could have transport times of literally 60 plus minutes. We even have a task force set up by GETAC to look at issues facing rural areas. What happened to the task force to look at urban problems? In Houston, we only have two Level I Trauma facilities and a limited number of critical care beds in those facilities. (Compare these figures to other urban areas and Houston almost becomes a 'special urban/frontier area') Combine this with the fact the neurosurgeons are scarce and we have a problem that far outweighs (by sheer number) those in rural and frontier areas. Yet some state monies are allocated based on need of frontier areas first.

- In short, some feel that EMS needs a gallant steed to ride into professionalism, quality education, better pay, better this and that. Fine, we need to select the steed and then make sure we have not selected a Trojan Horse! We need to find that animal fast, lest it appear we are only mounting ourselves and using a whip to get a dead horse to the finish line. Stop swallowing camels and choking on gnats.
- There is a continuing problem with the various hospitals we use not agreeing on what diversion means. While there are published guidelines, there is apparently no agency with the ability to make certain these guides are being applied in the same manner by each hospital.
- Ref: TDH/Bureau of Emergency Management: I deal with TDH on the EMS side and on the Hospital licensing side. There is as much difference as daylight and dark in these 2 agencies. The EMS administration is straight forward, and responsive to the needs of the license holder. Expectations are outlined in an understandable straight forward format and answers to questions readily available.
- I would like to see TDH establish minimum treatment protocols that are used state wide
- The Bureau of Emergency Management has done an excellent job in the past. They are confronted with a diverse state with diverse issues. They have some hard issues to deal with related to rural EMS vs Urban. The leadership appears to be stable and I have faith that EMS will continue to improve as long as we focus on the patient. We should be very cautious that we do not take the same path as nursing. That is, that we educate ourselves into ignorance.
- My personal view of this agency is based on my 20 years in health care. This is bureaucracy at its worst. This agency has to be the most counter productive group I have ever dealt with. It needs to be abolished and rebuilt with different players.
- Interactions with the Hospital Licensing side of TDH is a Train Wreck at best. You can forget about a straight answer to any question out of this department. There seems to be one standard answer from this regional office to Austin to any request for help or guidance. *"We can't tell you how to do it but we can tell you if your doing it wrong."* This agency and its surveyors for the most part are arrogant and convey the attitude that you have done something wrong and they are there to punish you. They single handedly cost facilities hundreds of thousands of dollars attempting to come in to compliance with regulations that the agency itself doesn't understand. Application of regulations are left open to the surveyors interpretation of the law. The Hospital Licensing arm of TDH could take many lessons from EMS. Primarily the use of common sense. This agency should be an asset and a resource to Hospitals in maintaining compliance and improving the delivery of services, not as a punitive body.

- I hope that once this information is gathered and compiled, it will be made available in a searchable database. For many years, Texas EMS has needed to be able to benchmark areas such as response times, staffing, service levels, etc. The information should not include the service or exact location, but wouldn't be nice to see what the average response time across the state is for services of your size?

