

Sustainable Rural EMS: Navigating Change

An Introduction and Guide

September 2021



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This project is/was supported by the Health Resources and Services Administration (HRSA) of the U.S. Department of Health and Human Services (HHS) under grant number UB1RH24206, Information Services to Rural Hospital Flexibility Program Grantees, \$1,009,120 (0% financed with nongovernmental sources). This information or content and conclusions are those of the author and should not be construed as the official position or policy of, nor should any endorsements be inferred by HRSA, HHS or the U.S. Government.

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Introduction

This guide is designed to assist rural communities in navigating a change from unsustainable volunteer emergency medical services (EMS) and ambulance service models to those that are sustainable. This guide is intended to direct community leaders through change based on a stepped process that has been used in rural communities throughout the U.S.

Does Your Community Have an EMS Problem?

For more than five decades, rural ambulance services across the U.S. have been staffed largely by volunteers. For many reasons, however, volunteerism is seriously declining, even at a time when the need for rural EMS is increasing.

As volunteerism declines and rural ambulance staffing becomes more unpredictable, it would be prudent to ask if your community has an EMS problem. As in all things that involve life, health, and safety, early recognition is important and can prevent disaster.

Your local volunteer ambulance service plays a vital role in the safety and well-being of residents and visitors to your community. Likely, your ambulance service has responded reliably over the years at all hours of the day and night. Residents and visitors have come to expect this level of service without giving it much thought. Indeed, throughout our nation, we expect quick emergency services (ambulance, fire, police) whenever we call 9-1-1.

Recognizing early indicators of a problem helps ensure there is never a time when emergency medical help is needed, and no one responds. This potential situation is not hypothetical. Increasingly, rural ambulance services are being called and are unable to respond. In a survey of rural ambulance services in South Dakota in 2016, one-third reported not being able to

respond because of a shortage of volunteers and another one-third reported delays due to insufficient staffing.¹

Below is a list of common early indicators that your community has an EMS problem, and a change may be needed.

- Volunteers report the need for more volunteers.
- Volunteers display frustration and exhaustion.
- A few volunteers carry most of the workload. There are not enough active volunteers to spread out the workload of ensuring the ambulance is available 24/7.
- Ambulance response is delayed. Volunteers take longer to get to the ambulance and start their response.
- Volunteer recruitment is continuous and never meets demand.
- Volunteers express concerns about increasing demands for training, certification, and recertification.
- Volunteers express guilt about leaving town to shop or recreate because of a lack of volunteers. If a volunteer leaves town there may be no other volunteer available to respond to a call.
- Community members express concern about the reliability of ambulance response.
- Community members express concern about whether the service will exist in the coming years.

Concerned citizens should ask about these indicators. Are they present in your community? What are volunteers, key stakeholders, and residents saying? Any of these indicators are a suggestion that change may be needed.

Your ambulance service volunteers are likely to be the first to recognize early indicators of an EMS problem in your community. As volunteerism declines, active volunteers may report high levels of stress, frustration, exhaustion, burnout, and a loss of fulfillment in their ambulance work. Volunteers also commonly notice the following items:

- A decreasing number of active and engaged volunteers

¹ 2016 Survey of all South Dakota EMS Agencies conducted by SafeTech Solutions, LLP

- Inability to recruit replacements in adequate numbers
- Holes in the call schedule (if they have a call schedule)
- Feeling personally responsible for any emergency with a bad outcome when they are out of town
- Frustration with fellow volunteers who are no longer are committed to working on the ambulance
- Wanting to retire from the role but not wanting to let others down
- Frustration with state requirements for training, education, certification, and recertification
- Weariness with long-distance transfers and transports of patients to regional hospitals
- Emotional upset after dealing with a heavy load of human trauma and tragedy
- Unwillingness to continually sacrifice family, holidays, and vacations for the ambulance service
- Perceived lack of support from the community

Even if they experience these common indicators, volunteers may not speak up. Many EMS volunteers have a deep sense of duty and service, and they will sacrifice too much of themselves and their families before complaining aloud. Additionally, when volunteers don't know how to fix the problem, they are likely to mask their feelings. Being a good EMS responder demands the suppression of emotion while responding to calls and caring for patients. This suppression of emotion often become engrained and shows up when responders are not on duty.²

As volunteerism takes its toll, call-takers and dispatchers at the local Public Safety Answer Point (PSAP) may begin to notice delays in volunteers' response. They may notice that the ambulance service no longer responds promptly and must be paged multiple times. Likewise, the local hospital, clinic, or nursing home may notice that it has become more difficult to summon or schedule an ambulance to transfer a patient. Law enforcement officers may experience ambulance delays at the scene of an accident. Local schools and other organizations may find it increasingly difficult to schedule an ambulance to stand by at a sporting or public event.

² Guy, M.E., Newman, M.A. and Emel Ganapati, N. (2013), "Managing emotions while managing crises", *International Journal of Emergency Services*, Vol. 2 No. 1, pp. 6-20. <https://doi.org/10.1108/IJES-07-2012-0033>

Residents, too, may become concerned. They may see articles in the newspaper about volunteers leaving or retiring from duty. They may be asked to volunteer. They may notice the permanent recruitment sign in front of the ambulance building. A resident calling for an ambulance may notice it takes a long time for ambulance to arrive. However, many rural residents may not know or recognize the struggles their ambulance service volunteers are facing until the situation is very grave.

Why Can't We Simply Fix Volunteerism?

Because rural EMS has, since its inception, relied on volunteer ambulance services, it is tempting to believe that fixing the volunteer problem will lead to a viable EMS solution. Can't we just find and recruit more volunteers and the ambulance service can continue as it always has? Our experience proves otherwise.

What is a volunteer?

For the purpose of this guide, a volunteer is someone who is not paid full regular wages for their work. Many volunteer ambulance services pay some level of compensation to their volunteers. This compensation may be an hourly call pay stipend or a per-response stipend, but the compensation is less than regular per/hour wages.

First, most volunteer ambulance services report significant challenges associated with finding and keeping volunteers, as well as sustaining the availability of volunteers during certain times of the day and week. This challenge mirrors national trends in volunteerism.

A 2018 report on national volunteer rates demonstrates a continuing decline in Americans' willingness to volunteer (across all fields, not just EMS). Volunteerism reached a high of 28.8 percent following the 9/11 attacks in 2001, but since that time has experienced a pervasive decline. Rural volunteering fell from 30.9 percent in 2003 to 25.3 percent in 2015. The

report states, “Fewer Americans are engaging in their community by volunteering and giving than in any time in the recent past.”³

The decline in EMS volunteerism appears to be a growing trend that is showing no signs of reversal. Ongoing research conducted by the EMS consulting firm SafeTech Solutions among rural volunteer ambulance services across the nation suggests the following causes of declining volunteerism in EMS.

- Socioeconomic changes: Rural individuals and families report needing to work more hours and more jobs to support themselves and their families. People report commuting greater distances to jobs. These socioeconomic changes are related to changes in agricultural business, manufacturing, health care, and retail businesses.
- Changing demographics: Rural communities across the nation continue to become older and grayer as young people leave for urban areas.⁴
- Increasing demands of the role: The demands on volunteers have increased. Emergency medical technicians (EMTs) are expected to know more, provide higher levels of care, and be responsible for more detailed patient care reports. A smaller roster of active volunteers means fewer volunteers must do more. Many leaders and educators of volunteer EMS agencies believe testing for basic EMT certification has become more difficult with the use of online computer-based testing. Some rural test-takers may find the computer-based testing process intimidating when they have only previously taken paper-based tests.
- Less commitment to the local community: Rural communities continue to undergo significant sociological changes. The commerce center of rural America has moved from locally owned and operated Main Street businesses to regional box stores where people shop often without a relationship or connection to the people or stores with which they are doing business. Oftentimes, younger generations experience less of a

³ From an analysis of data from the U.S. Bureau of Labor Statistics and the Census Bureau’s Current Population Survey (CPS). Reported in the University of Maryland School of Public Policy (2018), “America’s Volunteers? A Look at America’s Widespread Decline in Volunteering in Cities and States.”
https://dogood.umd.edu/sites/default/files/2019-07/Where%20Are%20Americas%20Volunteers_Research%20Brief%20_Nov%202018.pdf.

⁴ The Older Population in Rural America: 2012-2016, SEPTEMBER 23, 2019, REPORT NUMBER ACS-41, AMY SYMENS SMITH AND EDWARD TREVELYAN, United States Census Bureau
<https://www.census.gov/content/dam/Census/library/publications/2019/acs/acs-41.pdf>

connection to the small towns in which they live than have previous generations⁵, thus younger people may be less likely to volunteer.

- Changing attitudes about volunteering: young people today are less likely to volunteer than previous generations, and how they volunteer and why is changing. Volunteering in America has declined since 2005 in every age group. More specifically, about 25 percent of teenagers volunteered in 2015, down from 28 percent in 2005—ending 30 years of rising volunteerism among high school-age Americans. This decline in youth volunteerism continues.^{6,7}
- The emerging generation also is more likely to ask, “Why must EMS be volunteer?” They believe EMS positions should be paid in the same way rural positions in law enforcement, education, public works, or other areas of health care are paid.
- The regionalization of health care: Because of the regionalization of hospitals and health care facilities, volunteering is demanding more time to transport patients to distant tertiary hospitals and between health care facilities.

As the number of volunteers on rosters declines, fewer people are left carrying the load. Some volunteers report high levels of stress related to ensuring someone is available for calls. Some services are operating with two to five volunteers taking the bulk of the call time and responses.

All of the problems associated with volunteer ambulance services illuminate the manner in which rural EMS has long been viewed, valued, and funded. While rural communities have viewed public works, schools, public health, and law enforcement as *essential services* and have paid the full cost of these services through taxes, taxing districts, fees and other county, state and federal resources, EMS has not been viewed nor valued as an essential service and funded as such. The volunteer ambulance service model has kept the expenses of operating rural EMS low. At the same time, however, volunteerism has hidden the full cost and value of rural EMS, to the point that few people truly recognize and understand the real and full cost of labor in ambulance service operations.

⁵ Gieling, J., Haartsen, T., Vermeij, L., Strijker, D. (2019). "Out of love for the village? How general and selective forms of attachment to the village explain volunteering in Dutch community life." *Journal of Rural Studies*, Volume 71, Pages 181-188 <https://doi.org/10.1016/j.jrurstud.2018.06.008>.

⁶ Grimm, R., Jr., and Dietz, N. (2018). "Where Are America's Volunteers? A Look at America's Widespread Decline in Volunteering in Cities and States." Research Brief: Do Good Institute, University of Maryland.

⁷ Carr, P., & Kefalas, M. (2009). *Hollowing Out the Middle: The Rural Brain Drain and What It Means for America*. Beacon Press.

Despite challenging statistics and clear trends, many ambulance service volunteers across the nation persist in demonstrating a determination to preserve the volunteer model for the near future. This determination emerges from a variety of sources, including:

- a desire to preserve the status quo, pride, and identity that local ambulance services give a community;
- a sense that a successful volunteer EMS system demonstrates local independence;
- a lack of faith that other viable options exist;
- a reluctance to lose the intrinsic rewards associated with being a paramedic, EMT, emergency medical responder (EMR), or driver in the ambulance service;
- fear of what might replace the current service;
- a lack of leadership to navigate change.

As communities and volunteers recognize and acknowledge the challenges associated with declining volunteerism, their responses and actions will be dictated by what they believe. If they believe that they can preserve an all-volunteer model and continue to recruit enough volunteers to operate, or if they believe that there are no alternatives to all-volunteer models, their response and action will be focused on fixing, preserving, repairing, propping up, and maintaining volunteerism. As long as this belief remains strong within the ambulance service and community, any exploration of change is likely to flounder.

However, when there is a recognition and acknowledgement that an all-volunteer model for providing ambulance services is not sustainable, communities can manifest important changes in thought, response, and action.

Necessary Ingredients to Change

Recognizing and acknowledging the unsustainable nature of volunteerism is a first and necessary step toward making change. However, it is not the only ingredient to finding a solution to your EMS problem. There also must be a real hope that there is a better way, a sense of urgency, a coalition of people who care, strong change-oriented leadership, and a willingness to take the next step. Without each of these ingredients, change will not occur.

Change begins when someone catches a glimpse that things can be better. This does not mean having all the answers or knowing the exact process, way, or outcome. In fact, big human accomplishments like putting a man on the moon started with a few people simply imagining something different.

There are many rural communities, counties, and regions across the nation stepping up to address the rural EMS problem. You are in good company. Many folks just like yourself are finding ways to navigate change. Consider connecting with other communities in your region that are in the process of change. Borrow some of their hope, experiences, and ideas. If there is no sense or belief that things can be a better, nothing changes.

The glimpse of better things needs to be accompanied by a sense of urgency. A sense of urgency is the catalyst to change. Urgency overcomes our preference for the status quo and gets us moving. Creating urgency is critical to the change process. Urgency can come from crisis, but other things create urgency, as well. Making specific decisions and setting hard dates and timelines creates urgency. Vagueness delays action. A rural ambulance service in Eagle Bay, New York has recently announced it will cease operation at the end of 2021 due to a shortage of volunteers. This clear deadline is creating attention and fostering action by community leaders, residents, and neighboring services.

Rural residents will continue to accept the gift of a few remaining volunteers sacrificing everything to keep the service going, but when volunteers set a specific future date for no longer operating, the urgency of that date stimulates action. To get things moving in your community, create a sense of urgency by speaking up about the actual number of active volunteers. You could also ask the local newspaper to write an article about what it would be like to not have an ambulance service. Urgency is also created when you stop providing stand-by services or set a date for ending services. Without real urgency, change rarely happens.

Another important ingredient in the change process is that people must care. Does your community care enough about ambulance services to invest in the change process? Do they care enough to come together and act? People often avoid change because there is comfort and perceived security in the way things are now. However, human history and progress is a story of continual change. "There is no power for change greater than a community

discovering what it cares about,” writes community and management consultant Margaret J. Wheatley.

Big change, especially at a community level, also requires bold leadership. An individual or a group must lead the way. Moving from an unsustainable ambulance service model to a sustainable one takes courage, decision-making, patience, and tenacity. New sources of funding and revenues will likely need to be developed that will necessitate broad support, agreement, and collaboration throughout the community. None of this will happen without leadership.

Throughout this guide, we will continue to point out the role of leaders and leadership. Leaders do not need to have the answers or know exactly how to proceed. They simply need to have the courage to recognize a need and be willing to rally others in moving forward. [Appendix A, Leading Rural EMS Change](#), provides more guidance to those stepping out to lead.

Finally, the journey of change is made up of steps. While this guide cannot predict where you will end up, nothing will change if you do not take the first step.

Six Steps to Change

This guide advocates for a six-step process to change. These steps emerge from working with communities around the nation and observing common steps in the way communities approach moving from unsustainable volunteer ambulance services to sustainable alternative models.

The six steps to change are as follows, each of which is described in detail below:

Step 1. Form an EMS Working Group to lead the change process.

Step 2. Conduct a formal assessment of your current ambulance service and situation.

Step 3. Share assessment findings with the community.

Step 4. Explore alternative EMS models and choose the best model for your community.

Step 5. Obtain community support for the change process.

Step 6. Implement the change.

Each step is about learning and doing. Each provides information and demands leadership and action. When done thoroughly, each step takes significant time. Many variables will impact how long this work will take; however, leaders should plan for anywhere from 12-36 months.

The steps build upon each other. They should be approached sequentially and should be completed thoroughly before proceeding to the next step. If communities skip steps or fail to take the necessary time to complete each step in the recommended order, the entire change process is in danger of failure.

Each step is described in detail; however, none is an exact or precise prescription. The early steps are more detailed than the later steps. Step 2, conducting a formal assessment, is the most detailed and will take the most time and resources. It is also one of the most important steps in understanding the path forward and creating community buy-in. Leaders are encouraged to seek out experts along the way for additional guidance and help.

Finally, augments to the stepped process are expected. As change-leaders gain an understanding of their local EMS system and needs, they will be able to work with the complexity of making the best choices for their communities and navigating the change process.

Step 1. Form an EMS Working Group to Lead the Change Process

Once you have recognized that all is not well with your volunteer ambulance service, and you feel or create an urgency to do something, your first step is to reach out to others in the community who can help you make a change. Forming a group of like-minded community leaders enlists a variety of viewpoints to investigate and understand the current situation and imagine a

better future. It also can create urgency for, investment in, and ownership of the current and future state of EMS in your community.

When volunteer ambulance services were struggling to survive in central Wyoming, key stakeholders from seven communities came together to work on a solution. The group included local leaders, representatives of local government, ranchers, and concerned citizens. This working group led to the creation of South Central Wyoming EMS, a consolidated ambulance service that serves seven communities (most of Carbon County) and is formed as a Joint Powers Board. This solution emerged from the formation of a working group that navigated all of the many challenges and concerns of working together.

Gather a broad coalition of community leaders and stakeholders. The group needs to be made up of people who know the community, have a stake in it, and possess leadership capabilities and experience. The group should include the following:

- concerned residents;
- local professionals such as business leaders and attorneys;
- representatives of municipal and county government;
- school administrators;
- hospital, clinic, or long-term care administrators;
- clergy;
- members of affinity groups, such as military veterans;
- representatives of law enforcement and fire; and
- volunteer EMS representatives.

The group cannot be made up of ambulance providers and a few sympathizers. It must have recognized community leaders to give it horsepower. However, it is not necessary that your EMS Working Group be sanctioned by local government or the local ambulance service. Keeping this group independent may give it more latitude to explore issues and potential solutions. If the group is sanctioned by local government, ensure that you clarify the groups authority and empowerment.

You may be tempted to ignore this step, instead rendering all the work to volunteer ambulance leaders. This is a mistake. An old African proverb says, "If you want to go quickly, go alone. If you want to go far, go together." The

wisdom of this proverb suggests that the successful journey of change needs others and is a collaborative process.

Rural ambulance service is a community service. It needs broad community support. Involvement and participation from a group of key stakeholders brings awareness and builds communitywide understanding and support.

Recruiting group members will take some time. Seek first to enlist one influential person in the community. This person may be a local business owner, a political leader, a school administrator, a professional – their specific role is not as important as their ability to help others recognize the importance of the issue and enlist support. Then get that influential person to help recruit others. Carefully select people who can move the process forward and avoid selecting people who will thwart the process.

Six to twelve members is a good number for your EMS Working Group. Fewer than six may indicate a lack of community support. More than 12 can be difficult to manage and may impede working through the various challenges. Again, while this group will include representation from the current volunteer ambulance service, it must be made up primarily of people other than ambulance volunteers.

Once the group is recruited, plan your first meeting. The goal of the first meeting is to formally establish the group, agree on a charter, elect group leadership, discuss empowerment and a decision-making process, and plan for regular meetings. The first meeting should be well organized with a clear agenda and a commitment to end on time. This meeting should be facilitated by someone who is experienced in leading meetings and is respected within the community and group. See [Appendix B](#) for a Sample *EMS Working Group First Meeting Agenda*.

Your EMS Working Group must have a clear charter that lays out its purpose and the scope of its work. See the sample charter below.

EMS Working Group Charter

As operating today our local ambulance service, (name of agency), is facing significant challenges. The charge of the EMS Working Group is to:

- Create awareness among community leaders about the current situation and deepen our knowledge about rural EMS and its needs, costs, and sustainability.
- Build community understanding and consensus that volunteerism likely will not be a viable long-term staffing option for our local ambulance service.
- Involve the community in a discussion about the future of local EMS.
- Ensure current operations are supported and can run safely and humanely for the remaining volunteers and period of operation.
- Proactively plan for change, including identifying criteria for knowing when the current operational model must change (before an adverse event).
- Explore the true and full costs of local EMS, including the full cost of labor.
- Identify a menu of options for creating a new era of ambulance service in our community. Use outside consultants as needed.
- Investigate the most achievable options.
- Provide collective leadership for developing and executing an achievable plan.

Source: SafeTech Solutions

Finally, the inability to form an EMS Working Group or lack of interest from potential participants signals a lack of understanding and/or a lack of commitment or concern about EMS within the community. It may be difficult to accept, but not all communities and their leaders want to put in the time, effort, and resources toward assuring the continuation of the local ambulance service. Because of this lack of community support, some ambulance services will close. EMS is a community service that must have community support to be sustainable.

Step 2. Conduct a Formal Assessment of Your Current Ambulance Service and Situation.

The first major task of your EMS Working Group is to gain an understanding of your community's need for EMS, the current state of the local ambulance service, and regional resources. This is a simple practical assessment designed to give the EMS Working Group a solid grasp of the current situation.

The objectives of this assessment are to inquire, understand, and find clarity around six elements, each of which is described in detail below.

- Assessment Element A: What is the need for ambulance services in your community?
- Assessment Element B: Describe the organization and organizational structure of your existing ambulance service.
- Assessment Element C: Is your current ambulance service both reliable and sustainable?
- Assessment Element D. Describe the financial state of your current ambulance service.
- Assessment Element E. What is the full cost and value of your current ambulance service?
- Assessment Element F. Describe the regional EMS resources available to your community.

The assessment process is as important as the result. The process involves much more than checking boxes and totaling a score. To navigate change, your EMS Working Group needs to not only gather data and information, but also needs to understand the unique characteristics of your community and region, needs, and resources.

There are no right answers. Each element of the assessment will include both learning and gathering data and information. Your goal should be to use inquiry as a tool to prepare your group to make the best possible decisions about the future of EMS in your community.

Your assessment process likely will take several months and require the cooperation of a variety of entities and informants. You may want to hire a consulting firm to conduct the assessment.

Using a Consultant for your Assessment

Your EMS Working Group may choose to have an outside consulting firm conduct your assessment. Consulting firms with expertise in rural EMS can gather all the above data, make an analysis of the reliability, sustainability, and quality of the service, and provide recommendations that fit the community's unique needs. Such assessment can cost between \$20,000 and \$50,000 depending on the scope of the assessment and the quality and reputation of the consulting firm.

The best way to choose a consulting firm is to use a known EMS consultant with an established reputation and/or to create a Request for Proposals (RFP). An RFP is a document that is used to invite consulting firms to submit proposals and bid on the project. The RFP provides the specific scope of work and the guidelines for the submission of a proposal. Typically, RFPs include the elements listed below.

- Purpose of the request
- Time schedule for when proposals are due
- Specific instructions for proposers (how and where to submit proposals)
- The specific elements that the proposal must contain
- The selection criteria
- Terms and conditions
- Scope of work
- How work will be evaluated
- Other requirements (insurance and companies etc.)

Selecting the right proposal and consultant should be guided by the following:

- the proposal is professionally prepared and on time;
- the proposal follows the RFP and adequately addresses the specific elements of the RFP;
- the proposal explains the assessment process in detail and lists the specific deliverables;

- the consultants will spend adequate time in your community, interview a variety of stakeholders, and gather both qualitative and quantitative data;
- the consultants clearly have a track record of leading change in rural EMS communities;
- and the consultants will present their findings and recommendations in person.

Use the proposals to weed out unqualified bidders. But be sure that you talk with each possible consultant to explore their working style and the goodness of fit for your community. Check out references. Do not let the cost alone guide this decision. You will want a consultant that will both assess and help illuminate the path forward.

Assessment Element A: What is the Need for Ambulance Services in your Community?

The goal of this element is to use inquiry to better understand the needs and drivers for ambulance services in your community. Your EMS Working Group needs to know:

- Is there a solid need for ambulance services in your community?
- What might be the consequences of not having local ambulance services?

There are no right or wrong answers to these questions. However, your EMS Working Group can get a sense of local needs and consequences by gathering the following data:

- A1. How often are ambulance services used in your community? What is the daily, monthly, and annual call volume?
- A2. What are the boundaries of the ambulance service's response area? How are these boundaries determined? If your community does not have an ambulance service, who responds and how is the service area divided? When your ambulance is busy on a call and there is another call, what service is called?
- A3. Are there any dominant types of calls? Look for specific types of clinical calls that dominate call volume, such as opioid overdose, trauma from a major highway, calls for the elderly, etc.

- A4. Are there geographic areas in your community that have more calls than other areas? If so, explore why.
- A5. Where are patients typically transported? Here you want to understand to which medical facilities the ambulance transports and how long these transports take from time of the call until the unit is back at the ambulance station.
- A6. What are the number of 9-1-1 responses and transports vs. the number of interfacility transports? Interfacility transports are when the ambulance moves a patient from one health care facility to another (e.g., from a local hospital or nursing home to a regional hospital or care center).
- A7. How many times per month or year is the ambulance service experiencing multiple calls at the same time necessitating more than a single ambulance unit?
- A8. How often is the ambulance service being asked to post or cover special events, such as sporting events or large public gatherings?
- A9. Do local hospitals, clinics or long-term care facilities have special needs for ambulance services?
- A10. How often is your ambulance service being used to back up or provide mutual aid to a neighboring ambulance service or community?
- A11. What are the unique geographic and/or climate issues impacting local ambulance response in your community?
- A12. What is the proximity in miles and response time of neighboring ambulance services?
- A13. What are the first responder resources in your community? Here you are considering non-transporting first responders such as fire department, first responder squad, or law enforcement (police, sheriff, or state police).
- A14. What would be the possible result of not having an ambulance service in your community in terms of how many times ambulance services will be needed and the approximate amount of time callers will have to wait for these services?

As this data is gathered and your EMS Working Group deepens its understanding of your specific situation, it will be better able to assess the intangible value of the services to local residents and the risks associated with not having local ambulance services. An important part of the EMS Working Group's charge is to enlighten the community and help the community decide if EMS is actually an essential local service worthy of the

same kind of essential service investment that communities and counties make in public works, education, and law enforcement.

Assessment Element B: Describe the Organization and Organizational Structure of Your Existing Ambulance Service.

This element seeks to bring clarity to your existing ambulance service's ownership, organizational structure, leadership, governance, facilities, equipment, and operational practices. Your EMS Working Group will further its inquiry through the following questions:

- B1. What is the ownership of the ambulance service? Ownership could be a local nonprofit corporation, a for-profit entity, a municipality or county government, a fire department or fire district, a hospital, or some other entity. Some rural ambulance services have never organized themselves as official business entities.
- B2. Does the organization meet any/all state requirements for licensure by the state or other regulators?
- B3. How is the ambulance service governed and to whom is the organization accountable? If there is a Board of Directors, it is important to know if the Board of Directors is made up of operational members of the organization. Is governance more club- or business-like?
- B4. How are organizational leaders and members selected? Obtain or make an organizational chart.
- B5. How is accountability practiced within the organization? This question is about dealing with volunteer/employee performance and ensuring operational and clinical performance is of an acceptable quality.
- B6. What does the organization own? This is a description of the organization's facilities, vehicles, and major equipment assets.

Assessment Element C: Is your Current Ambulance Service both Reliable and Sustainable?

The goal of this element is to understand the response reliability and long-term sustainability of your current ambulance service. It seeks to understand if the community can trust that the ambulance service is and will

always be able to respond when requested and, as operating today, if the ambulance service is sustainable.

Reliability is the most important indicator of an ambulance service's performance. Reliability is about being able to always respond in a timely manner when summoned. Reliability is a way of talking about the confidence a community has in an ambulance service's response. EMS is expected to respond promptly. This prompt response is needed at all times of the day or night and on weekends and holidays. Because of the emergent potential life-saving nature of EMS, delays and missed calls are not acceptable.

Sustainability relates to the long-term viability of your ambulance service. Sustainability is an evaluation of an agency's likelihood of continuing to be in business in the coming 3-5 years and beyond. While there are many issues associated with sustainability, the greatest threat to rural ambulance services sustainability is having enough trained people to be available for calls and staff the ambulance. Whether or not an agency is sustainable is impacted by the number of active people on its roster, the roster trend and the service's ability to recruit.

There are nine key areas of inquiry concerning reliability and sustainability. Your EMS Working Group should seek input and data to answer the following questions, as well as understand each of these issues.

- C1. Does the ambulance service use a formal schedule and is the schedule consistently filled? Ambulance services, no matter how rural, cannot be part-time. They must be able to staff and operate 24 hours-a-day, seven days-a-week. Staffing and response reliability is ensured through establishing a predetermined schedule in which at least two appropriate personnel are assigned to each hour or block of hours of each day.

Volunteer services often operate without a schedule using an "all call" method in which everyone is summoned when a call for service comes. Those who are available respond. As rosters shrink, this "all-call" system leaves the potential that no one will respond. A schedule is a means of ensuring specific ownership for response. An inability to fill a schedule suggests there may be times when no one is available to respond.

The assessment seeks to know if there is a schedule. If so, is the schedule consistently filled or does it have unfilled time slots? Unfilled

time slots suggest that there is a potential for the service to be unreliable because a specific volunteer is not responsible for that time.

- C2. Has the ambulance service missed requests for service in the past year because of lack of staffing? If so, how many? This inquiry is about the service's ability to respond to all calls when requested (provided the service is not already on another call). Reliable data for response reliability can come from the local 9-1-1 call center or PSAP. Data also may come from the ambulance service.
- C3. Is chute time prompt? Chute time is a measurement of the time from notification of the ambulance crew until the ambulance begins moving toward the emergency scene. Most volunteer ambulance services do not have crews waiting at the station. Volunteers respond from home, work, and elsewhere when needed. This measurement is controllable (total response times are not controllable because of distance, weather, and many other factors).

How rapidly crews can go into service and begin their response is a strong indicator of staff availability (e.g., whether or not people are available to rapidly respond) and staff engagement (e.g., whether or not they are motivated to be available and respond rapidly). There is no standard benchmark for chute time, but agencies typically set chute time goals of from one to ten minutes. Chute time should be a system-wide performance measure reported by the PSAP or agency dispatching the service and tracked over time. When chute time begins to increase, it is usually an indicator of staffing or motivation challenges.

Data for chute time can be obtained from three possible sources: the state's EMS data collection system; the local 9-1-1 dispatch center or PSAP; or the ambulance service. Many rural 9-1-1 dispatch centers (PSAPs) do not track chute time for ambulance services. The state's data or the ambulance service's records may be the most reliable for this data.

- C4. How many active people does the service have on its roster? Active volunteers are those who regularly take call (with exceptions for health, vacations, and special needs) and attend more than 50 percent of ambulance service meetings. A volunteer ambulance service scheduling two people 24/7 should have a roster of at least 14 active volunteers with a balanced certification mix. This limits the amount of call any single person needs to take. With two people scheduled at all times, 14 active members could limit each volunteer's responsibility to

24 hours of calls per week (this does not account for vacations and other absences).

- C5. What is the five-year roster trend for active volunteers? This inquiry seeks to understand the past 10-year, five-year, and one-year trends in the number of active volunteers on the roster. A sustainable service will be replacing volunteers who leave person for person. This inquiry includes the ambulance service's ability to recruit new people. If the roster trend over the past 10 years, five years, and one year shows a steadily shrinking roster, the ambulance service is likely not sustainable.
- C6. Does the ambulance service have fewer than 10 active volunteers? When a volunteer ambulance service has fewer than 10 active people on its roster, it is very difficult to recover and recruit new people. With so few people sharing 24/7 call, the environment and culture often are characterized by high levels of stress that impede new volunteers from wanting to join. Small roster numbers also suggest a lack of community support and may indicate that the potential volunteer pool is too small. In many rural communities today, it takes at least 100 people to produce one active volunteer. For example, to have 14 active volunteers your service area would ideally have a population of 1,400.
- C7. Is the schedule or call time load safe and humane? Regardless of how few or many calls a service responds to, being "on call" is stressful and activity-limiting. There is always the potential for back-to-back calls. Adequate rest, sleep, and time off are essential to keep volunteers healthy and maintain the intrinsic rewards of volunteering. In most circumstances, no volunteer should ever be on call more than 80 hours in any given week. Ideally, call time should be limited to 48 hours per week. If the service has multiple calls in a 24-hour period, no volunteer should be left on call if they have not had adequate sleep. Particular attention should be paid to long transfers and providing relief when volunteers have made a long transfer.
- C8. Are a few volunteers carrying the majority of the call and response load? As volunteer ambulance services struggle to recruit, the bulk of call time and most of the calls often fall to a small group of two to five people. Such a situation puts significant stress on that small group of people and creates an unsafe and unsustainable environment. The members of these small groups often report feeling guilty for trying to take time off or leave town.

- C9. Is the internal culture of the ambulance service attracting new volunteers? Successful volunteer ambulance services create a volunteering culture that is inviting, warm, fun, and family-like. But these services also have clear professional and educational expectations and enforced policies. In these organizations, creating a respectful volunteering environment is a priority. Bad attitudes, ongoing interpersonal conflict, and non-professional behaviors are not tolerated. Ongoing and interesting training and education are priorities, and volunteers are recognized and rewarded in a manner that is meaningful to them.

Through the process of inquiring into these nine questions, your EMS Working Group will obtain important data, understanding, and insights that will enable you to tell a powerful story about the need for change.

Assessment Element D: Describe the Financial State of Your Current Ambulance Service

The goal of this element is to understand the current financial state of your volunteer ambulance service. This is not an in-depth analysis nor a financial audit. It is a means of understanding current revenues, expenses, assets, liabilities, and financial practices of the ambulance service.

The needed information may be found in the following documents:

- statement of financial activity, budgets, or budget reports;
- statement of financial position or balance sheet;
- and/or statement of cash flow.

From these documents, your EMS Working Group should seek to answer the following questions:

- D1. What are the total annual expenses for the ambulance service? In reviewing expenses, separate labor expenses from non-labor expenses.
- D2. How does the ambulance service handle capital expenditures and purchases? Ambulance services make large capital expenditures for vehicles and equipment. Note how these large purchases and expenses are accounted for and amortized.

- D3. What are the total annual revenues for the ambulance service and what are the specific sources of these revenues? This data should account for all income, including revenues from billing for ambulance transport, donations, grants, governmental subsidies (from taxes or general funds), billing for standby services and education, as well as fundraising.
- D4. What debt or liabilities does the organization have? This may include mortgages, loans for vehicles, or lease obligations.
- D5. Does the ambulance service bill for ambulance transportation services or other services? Who performs the ambulance transportation billing and what is an average charge for services? Some volunteer ambulance services do not bill for their services. Those that bill may use a billing agency or perform the billing themselves.
- D6. What is the payer mix of billing for ambulance transportation? This is the percentage of payers that are governmental (Medicare, Medicaid, or other governmental), private insurance or private self-pay, or no pay. The main goal here is to understand the revenue potential for ambulance transportation billing.
- D7. Does the ambulance service have reserves and what are its net assets?

Note that it may be challenging to obtain financial records. Private, for-profit organizations or larger organizations such as hospitals or fire departments who own the ambulance service may not be willing to share financials. Public organizations may provide only a budget document and may not provide clear information on revenues. Some volunteer ambulance services may have no organized financial record keeping. If services are unwilling to provide financial data and the EMS Working Group has limited authority it may be necessary to estimate the expenses and revenues.

However, once the data and information of this element is gathered and organized into an easy-to-understand description that accounts for assets, liabilities and annual operating expenses and annual revenues, this information will be key to decision-making.

Assessment Element E: What is the Full Cost of Your Current Ambulance Service?

In navigating change, your EMS Working Group and the community need to understand the full value and cost of having volunteer ambulance services in your community. This understanding is needed to tell a complete story about these services and help the community understand the value of the services they have now and what they need to pay for in the future.

Historically, the full financial value of a volunteer ambulance services has been hidden because volunteer labor was not financially valued.

EMS, and especially rural ambulance services, must be understood as standby services. Standby services are services that must be ready to respond at a moment's notice. The military, emergency rooms, and full-time paid fire departments are examples of standby services. They need to exist and be ready even when they are not busy. There is always a cost associated with readiness; however, rarely are these types of standby services continuously productive. In slow rural communities, there is more standby time than in busy urban environments.

Fifty years ago, as EMS evolved in America, there was no comprehensive planning for figuring out how to pay for ambulance services fairly and sustainably – especially rural services that must pay for large amounts of readiness or standby time. Without such planning, a default funding system developed that reimbursed ambulance services for medical transportation through billing insurance companies and patients for services provided. Eventually Medicare, Medicaid, and other government payers reimbursed ambulance services for transport.

The current ambulance transport reimbursement system works well when there is enough billable transportation volume to balance expenses and reimbursements. However, if expenses exceed reimbursements, an ambulance service will need to be subsidized to stay in business. A successful and sustainable ambulance service model has balance between revenues and expenses.

Revenues (reimbursement + subsidy) = **Expenses** (labor and all other expenses)

In urban EMS systems where ambulances are kept busy and transport many patients, less subsidy is needed. In low-volume, rural systems where ambulances transport few patients, significant subsidies are needed. These subsidies historically have been donated labor, donated funds, grants, gifts, fund raising, subscriptions, and tax revenues. The largest of these subsidies has always been donated labor in the form of volunteers.

When rural ambulances began, it made sense to use volunteers. Labor is the largest expense in a service business, and rural services had few calls so paying staff did not make good business sense. But as volunteerism declines, it has become important to recognize volunteer labor as a subsidy and account for its value. This is important for planning and for recognizing the contributions made by volunteers.

A rural ambulance service operating and staffing an ambulance unit 24/7 with uncompensated volunteers costs its community \$570,021 per year. This number is a minimum estimate based on extensive work with volunteer ambulance services across the nation. Each location and community will be different, and there are many variables, but this number is a useful starting point to understand the full economic value of a volunteer ambulance service. The expenses can be broken down using this formula.

Value of annual non-labor expenses	\$70,000
Value of annual labor expenses	\$500,021
TOTAL annual cost for ambulance service	\$570,021

The \$70,000 annual non-labor expenses include a facility, fuel, insurance, equipment, supplies, repairs, other administrative and miscellaneous expenses. This category also includes the amortized expense of a single vehicle spread over 10 years. Non-labor expenses could be significantly higher depending on the needs and structure of the organization providing services.

The \$500,021 in annual labor expenses accounts for the value of the donated labor. This calculation is based on the minimal labor expense a service would incur if it had no volunteers and had to pay regular staff wages. The value of a volunteer hour in the U.S. in April 2021 is calculated

to be \$28.54.⁸ Without volunteers, an ambulance service staffing one unit would need two staff members scheduled 24/7. That would require 17,520 hours per year multiplied by \$28.54/hour.

On the revenue side, an ambulance service can bill patients and/or their insurance companies for transports. If billing is done properly, a simple estimate suggests that an ambulance service billing for Basic Life Support (BLS) transports should expect to collect an average of \$750 per transport. This number will vary depending on location, payer mix (e.g., Medicare, Medicaid vs. private insurance, private payers, and uninsured), transportation distances (payments for mileage can be significant) and types of calls (9-1-1 vs. interfacility transfers).

To tell a full story about the economic value of your volunteer ambulance service and the amount of subsidy needed to have this service, your EMS Working Group should seek to show total expenses and the current subsidy provided by volunteer labor. It should seek to answer the following questions:

- E1. What are the annual non-labor expenses of the ambulance service? If unclear, use \$70,000 as a basic and reliable estimate.
- E2. What are the annual labor expenses? At least two people are needed to be available 24/7 or for 17,520 hours. Multiply 17,520 by \$28.54 (\$500,021) or the value of a volunteer hour in your state.⁹ Subtract from that total any stipends, call pay, or per call pay that is current being paid to volunteers.
- E3. What are the total annual expenses including labor and non-labor? This is the total value and expense of the ambulance service.
- E4. What are the total annual revenues collected for billing for patient transport? This can be the actual number from the ambulance service's financial data or estimated by multiplying the total number of annual transports by \$750.¹⁰

⁸ The value of a volunteer hour in the United States in 2021 was calculated by The Independent Sector. The source data for Independent Sector's estimates are based on the annual average hourly earnings (non-seasonally adjusted) for all production and non-supervisory workers on private non-farm payrolls. These annual earnings estimates come from the Current Employment Statistics (CES) database, which is available from the Bureau of Labor Statistics (BLS). <https://independentsector.org/value-of-volunteer-time-2021/>

⁹ State-specific volunteer hour values can be found at The Independent Sector website.

¹⁰ Keep in mind that the \$750 is a ROUGH estimate and will vary greatly depending on many factors such as amounts billed, services provided, distance transported, and the payments from Medicare, Medicaid, private insurance, and private payers.

- E5. What is the difference between the total expenses and the transport revenues? This is the amount of subsidy that the organization needs to survive. Volunteers are likely to be providing the bulk of the subsidy in the form of donated time/labor. The total value and subsidy can be represented in a formula. See the example below.

Non-labor expenses	\$70,000
Labor expenses	<u>\$500,021</u> (2 persons 24/7 at \$28.54/hr.)
Full cost	\$570,021
Transport revenues	\$90,000 (120 transports at \$750)
Needed subsidy	\$480,021

Representing the full costs and the needed subsidy are useful in helping your community understand the value of donated labor. In the above case, volunteers are donating a half million dollars of labor to make ambulance services possible in the community. While a community may be opposed to generating revenues to subsidize ambulance services, it should acknowledge that it has historically and currently receives services that are heavily subsidized by a few volunteers.

It is important to acknowledge that volunteerism has been an incredibly efficient way of providing ambulance service to communities. Volunteers have provided their local areas with a bargain. The full value of that bargain has been largely hidden.

It is also important to note that this bargain is becoming less of a bargain. Most volunteer ambulance services across the nation are no longer purely volunteer. Services have begun to provide stipends, per call pay and/or pay to be on call. These payments suggest that those people staffing the ambulances increasingly expect or want to be compensated for their time. Prudent planning demands that the full and real costs of the labor needed to operate these services be acknowledged.

Assessment Element F: Describe the Regional EMS Resources Available to Your Community

In addition to understanding your own ambulance service, your EMS Working Group needs an understanding of EMS beyond your own

community. Familiarize yourselves with your regional EMS system, including resources, organizations, leaders, the health of those agencies, and how they work together. The goals of this element are to understand how your community ambulance fits into the larger EMS system, and the capacity and resources around your community, with an eye toward opportunities for (or potential barriers to) collaboration. The elements contains both questions and suggestions.

- F1. Become familiar with the EMS system(s) in your area. Emergency medical services are often described as a system. Your EMS Working Group needs an understanding of EMS systems. Historically, rural EMS developed locally and organically and has largely been controlled and supported locally. This is changing. EMS and ambulance services can be delivered more efficiently and effectively as part of a system. The future of rural EMS and ambulance services likely will involve a more systematic approach with regional approaches to the provision of EMS.

An EMS system contains a variety of components that ideally work together in the delivery of emergency medical care. The basic EMS system components include:

- 9-1-1 emergency communications centers or PSAPs, where calls are taken, and resources are dispatched;
- first response agencies such as law enforcement, fire departments, and non-transporting rescue squads;
- ground ambulance services that respond and transport patients;
- air medical services that use helicopters and airplanes;
- community paramedics that provide primary health care within the community and may prevent the need for emergency response;
- and hospital emergency departments, trauma centers, and other specialty care centers (e.g., burn, cardiac, pediatric, and stroke).

Beyond these basic components are a variety of additional components that deal with quality, medical direction and oversight, regulation, the entire continuum of patient care, planning, emergency management, and disaster management.

Transporting ambulance service units are usually divided into two clinical categories based on the training and certification of their

crews: BLS or Advanced Life Support (ALS). BLS ambulances are usually staffed by EMTs. ALS ambulances are usually staffed by at least one advanced EMT or paramedic. ALS ambulance crews can perform more advanced medical interventions than BLS crews. You can learn more about the difference from the National Association of EMTs.¹¹

- F2. Develop a list of EMS resources within and beyond your community, township, county, borough, or region. Include PSAPs, first responder agencies, and transporting ambulance services and the clinical level of services they provide. Include air medical resources, noting where helicopters are based. Include hospitals and the level of service they provide. Many rural hospitals are critical access hospitals and do not provide specialty care such as burn, cardiac, pediatric, and stroke care. Include the nearest trauma centers.
- F3. Seek resource information. As you develop a list of EMS resources in your region, become curious about these resources. Seek in-depth information about the ambulance services that surround your ambulance service's area. Learn about the structure of these services, including ownership, whether volunteer or paid, and the level of clinical care provided. Ask your ambulance service if there are mutual aid agreements between your local service and these nearby services and obtain copies of those agreements. Find out if your ambulance service uses intercepts (a BLS ambulance meets with an ALS ambulance on the road to bring a higher level of care to the patient). Inquire about collaboration and how services help each other. Keep the curiosity going and learn as much as possible about regional resources.
- F4. Create a map of your service area boundaries. Creating a map can illuminate possibilities and help in the telling of your EMS story. The map can be created with a traditional wall map or electronically with mapping software. Place resources and service area boundaries on the map.

¹¹ The National Association of EMTs provides a short practical description of EMS, its levels, and how EMS works. This can be printed and used in public meetings. The pdf document can be found at <http://www.naemt.org/docs/default-source/about-ems/what-is-ems-for-web-04-17-2017.pdf?status=Temp&sfvrsn=0.46038588091233634>

- F5. Host a gathering. One of the best tools for understanding the state of EMS in your region and opportunities and challenges everyone is facing is to host a gathering. Likely, other agencies and resources in your region are experiencing fallout from declining volunteerism, as you are. With the goal of better understanding the potential for shared resources, emerging challenges, and creating relationships, plan an in-person meeting with representatives of regional EMS agencies and resources. Invite key stakeholders. Describe the gathering as a planning session in which your community is seeking input from regional EMS leaders, in preparing for the future and creating sustainable ambulance services. Do not hesitate to reveal that you have concluded that your volunteer model is not sustainable. Set a date, time, and location that is convenient and far enough in the future for people to plan. Call representatives directly and ask for a commitment. Plan to serve refreshments.

Start the meeting by explaining the charge of the EMS Working Group and that this gathering is one of the steps in your change process. Explain your current circumstance and ask each of the resource representatives to speak about their agency or services. Facilitate a discussion around the strengths and challenges facing EMS in the region. Treat this as a learning session. You are not asking this group to suggest or solve your unsustainability problem. You are simply hoping to learn as much as you can, understand the regional players, and create relationships that may be needed in the future.

- F6. Reach out to other resources. In deepening your understanding of potential resources, reach out to your state Office of Emergency Medical Services. This is the agency within your state government that regulates EMS in the state. Typically, these agencies are concerned about continuation and future of EMS in the state. While they may have limited authority and funding, they often are familiar with additional resources. Other organizations that can help will be state EMS associations or state ambulance and fire associations.

Summarize Your Findings

Having studied the EMS Assessment Elements described above, there is one thing left to do. Organize the data and information you have

gathered into a simple PowerPoint presentation. The presentation is a powerful way to reflect upon what you have learned and prepare yourself to tell a story about your findings.

Start your presentation by stating the problem and reason for forming your EMS Working Group. Be clear that the group was formed to guide a process of changing from an unsustainable all-volunteer ambulance service to a sustainable model. Then use the elements described above to tell your story.

- Summarize the need for EMS in the community
- Describe your volunteer ambulance service today
- Explain your current ambulance service's reliability and sustainability
- Present a high-level picture of your ambulance service's financial position
- Describe the full value of the ambulance services that your community has been receiving
- Identify EMS resources in your region. (Use your map)

Creating the PowerPoint presentation and discussing it as a group can be an illuminating process. Take your time with this activity and use it as a tool to better understand where you are and where you might go.

Step 3. Share Your Assessment Findings with the Community

The EMS Assessment described in [Step 2](#) has been all about learning. Now it is time to share what your EMS Working Group has learned with your community.

Without community engagement, the future will be difficult. In this step, your EMS Working Group will engage the larger community by conducting a brief survey of community residents and hosting a community meeting. In the meeting, you will share what the EMS Working Group has learned in the previous steps, as well as the results of the community survey conducted prior to the meeting. The goal of the step is to deepen community involvement, educate them, and plant the seeds of change.

Conduct a Community Survey

Surveys are a tool to gather data about a particular topic or issue. In this context, a brief survey of households in your community and the ambulance service's response area will serve multiple functions. The first is to gather data about residents' understanding and views of your local ambulance service. Second, you can use the survey to heighten awareness of the challenges faced by your local volunteer ambulance service. The survey can introduce the problem, briefly inform people, and introduce the EMS Working Group and its charge. Third, the survey can be used to stimulate interest, curiosity, and engagement about the issue at hand. It can ask people to engage with seven simple questions that will cause them to think about the issue and offer their opinions. Finally, the survey can be used as an invitation to more involvement by asking community members to attend future meetings.

There are a variety of methods used to conduct community surveys, including online surveys, focus groups, mail-in surveys, and telephone surveys. While any method is possible, this guide suggests using a mail-in survey sent to each household in the ambulance service response area. Mail-in surveys work well when they come from a local return address, use first class postage, and include a self-addressed stamped response envelope. While younger residents may respond better to online surveys, rural residents are often older, and may be most comfortable responding via snail mail. Resident addresses usually are easy to obtain through your local government and other sources and ensure that you are attempting to reach everyone in your service area.

What questions should you ask in your community survey? This guide recommends the following:

1. In the past 10 years, have you or a family member used the volunteer ambulance services in our community?
Yes/No/Don't Know
2. Were you aware that the ambulance service is having significant challenges finding and keeping volunteers who are regularly able to staff the ambulance?
Yes/No
3. How do you view having ambulance services in our community?
(Choose one)

- Essential (critical to our county)
 - Nice to have
 - Not needed
 - Do not care either way
4. If we do not have a dedicated local ambulance service in the future, would it be acceptable, in an emergency, to wait _____ minutes for an ambulance from outside our community?
- Yes/No
5. In the future, keeping an ambulance service in our community likely will require more funding for paid staff. Please indicate your willingness to provide financial support. (Choose all that apply).
- I (we) would be willing to pay more taxes.
 - I (we) would not be willing to pay more taxes.
 - I (we) would be willing to pay an annual fee to help fund this service.
 - I (we) believe ambulance service should be paid for by people who use it.
6. Help us better understand how you view EMS and ambulance services by choosing all of the following that are true for you?
- In living in a rural community, I (we) expect less services and do not expect EMS and ambulance services to be provided.
 - I (we) view EMS and ambulance services as a vital public service that our community must support.
 - EMS and ambulance services are as important as public works, law enforcement, and schools in our community.
 - Government should not be involved in the provision of EMS or ambulance services.
7. Do you plan to attend the upcoming community meeting on EMS and ambulance services in your community on (insert date) at (insert time) at (insert location)?
- Yes/No

Questions can be added or deleted, or you may create your own survey. Keep the survey short to improve response rates. Allow four weeks from the date the survey is mailed to tally responses. See [Appendix C](#) for a *Sample EMS Working Group Community Letter and Survey*.

Host a Community Meeting

Community meetings are a tool for engaging people on a topic. Getting people together around a topic demonstrates the importance of the topic. It ensures a common story and consistent information is shared about the topic.

Plan your community meeting for a date approximately six weeks after the distribution of the survey. This meeting is referred to as the “Houston, We Have a Problem” meeting because its goal is to demonstrate that an all-volunteer ambulance staffing model is not sustainable and seek public comment.

Remember, if you follow the recommended Six Steps to Change, your EMS Working Group has not explored options or made any decisions about the future. It has simply assessed the problem and is presenting its findings. This first community meeting is not about solving the problem, either. Its sole goal is to present a powerful case that change is necessary and ask people to listen. The EMS Working Group will host a second meeting ([Step 5](#) below) in the near future, in which recommendations for change will be presented.

Advertise your meeting as a community informational meeting about your local ambulance service. Invite the entire community. Reach out and personally invite key stakeholders. Choose a venue large enough to accommodate the expected audience but not too large. The COVID-19 pandemic aside, it is usually better to have a small, crowded space than a large empty space. Choose a date and time that will meet the availability of the most people and not conflict with other community functions or work hours. Plan 90 minutes for the meeting. Food or refreshments can serve as an incentive to attendance.

Your community meeting should be facilitated by representatives of your EMS Working Group. The agenda should be simple and include the following elements:

- welcome
- introduction of the EMS Working Group, its charge, and its work to-date
- state the purpose of the meeting;

- presentation of the assessment findings using the PowerPoint (this should take no more than 40 minutes);
- answer questions and invite comment and discussion;
- next steps;
- and adjournment.

Ensure the discussion portion of the meeting is well-facilitated. Consider limiting comments to one minute or less. Have several questions planned so you can direct the discussion and keep it on point. Consider calling on various community leaders to get their input. Keep the conversation moving and end on time. Thank people for their attendance and participation. Try to end on a high note, reminding people that there will be another meeting in the coming months with further discussion and recommendations. The discussion may continue informally after the meeting is adjourned.

It is difficult to predict what you might hear during the discussion. If your community is like other rural communities, people likely will want to talk about fixing volunteerism and suggest multiple reasons volunteerism could be viable (e.g., reducing EMT requirements, allowing anyone to drive the ambulance, providing various volunteer incentives). Some of the volunteers may agree that volunteerism is fixable. Don't argue. Simply continue to remind participants that the EMS Working Group has concluded that volunteerism is not sustainable. It may be helpful to chronicle the recruitment strategies that have been tried without success. Remember, as long as the community is focused on maintaining volunteerism, change will not happen.

Step 4. Explore Alternative EMS Models and Choose the Best Model for Your Community

There are many ways that EMS and ambulance services can be structured and delivered in rural communities and regions. In this step, your EMS Working Group is tasked with considering the various options and alternatives through the lens of what is possible, practical based upon what you learned in the previous three steps. Step 4 can take a significant amount of time. An outside expert or consultant can be useful to provide in-depth background on the various alternative EMS models and help match one of them with the unique needs and desires of your community.

Study Various Alternative Models

The first part of Step 4 is to familiarize yourselves with ambulance service and EMS delivery models. Delivery models for rural ambulance services continue to evolve. Those listed below are continuing to evolve into various hybrids as communities and organizations continue to seek efficient and effective deliver models. Reference [Appendix D](#) for additional resources related to alternative EMS delivery models.

Alternative Model 1. No Local First Response and No Local Ambulance Service. In this model, there are no local response and transport resources. Calls for emergency medical response are handled by response from nearby communities. In sparsely populated regions, response may take an extensive amount of time depending on distance, weather, and other variables.

Not all rural ambulance services will survive.

As populations decline in some communities, the ambulance service may close, as have other services and businesses. Other communities will find ways to regionalize services, just as schools, health care, and other services have been regionalized. In other communities, EMS and ambulance services simply will not be a priority. This guide can be used to practically plan for closing that is proactive rather than reactive to a crisis and honors the volunteers that have dedicated their time to the provision of EMS in the community.

Alternative Model 2. Local First Response without Local Ambulance Service. In this model, a non-transporting first responder agency responds to EMS calls with trained personnel and equipment. This agency may be the local volunteer fire department, a rescue squad, or local law enforcement. If willing, law enforcement can be equipped with the appropriate training and equipment. At the same time, dispatch initiates ambulance response from another community or locale. The ambulance expected to arrive after the first response and transport the patient, as necessary. Air medical resources also may be used to transport patients.

Alternative Model 3. Quick Response Unit. In this model, a single-person response unit (called a quick response unit or QRU) is stationed

locally or nearby in the region and staffed with an advanced EMT or paramedic. The QRU can respond quickly and stabilize the patient using ALS care while awaiting an ambulance that comes from farther away. Ambulance service may be at a BLS level, and the QRU paramedic may ride with the patient in the ambulance if needed. Ownership of the QRU can be part of the ambulance service or an independent response organization or part of another entity, such as a hospital or fire department.

Alternative Model 4. Locally Owned and Operated Ambulance

Service. In this model, a locally owned ambulance service is staffed by paid staff or a combination staff of paid personnel and volunteers. The ambulance service may be publicly owned (e.g., municipal, county, or fire service), private for-profit or private nonprofit. If call volume is low, the ambulance service will need to be subsidized in some fashion (e.g., general fund, special taxing district, sales tax, visitor's tax, etc.).

Alternative Model 5. Based Ambulance Service. In this model, an EMS organization or agency from out-of-town owns and operates an ambulance service that has a base of operation in your community. The owner agency may see your community's location as strategic to their operational model or want the billable call volume from your community. In this model, the ambulance organization may request that the local community provide a subsidy for services, in the form of direct funding or by providing facilities such as an ambulance base station.

Alternative Model 6: Regionally Owned Ambulance Service with or without an EMS Staffing Corps. Increasingly, the economies of scale available in the creation of regional ambulance services are becoming an attractive alternative to rural communities and regions. A regionally owned ambulance service is the product of mergers, consolidations, joint ventures, or joint powers authorities. In this model, the ambulance service is structured to provide efficient response to multiple communities and regions. Expenses are shared, and ambulance units may or may not be locally based. In a regional model, ambulance units can be moved and staged where most needed to optimize response time to the most patients.

An emerging rural EMS workforce concept that may be applied to regional ambulance services is the EMS staffing corps. This is essentially a staffing organization that provides paid staff to rural ambulance services. A low-volume rural ambulance service has limited long-term appeal to full-time

EMTs and paramedics. With this emerging concept, trained and certified personnel will travel to a rural community and staff the ambulance for a multi-day shift. This crew is then replaced with a new crew at the end of each shift. If the staffing corps is large enough, personnel can be rotated from rural areas to busier communities, in which the variety of work settings deliver higher employee satisfaction.

Alternative Model 7: Hospital-owned Ambulance Service. In this model, the ambulance service is owned by the local hospital or health care corporation. As the regionalization of health care necessitates the transport and transfer of patients, health care corporations are interested in owning ambulance services and controlling the flow of patients. Resources are deployed via regionalize response, QRUs, and other delivery models.

Alternative Model 8: Contracting for Ambulance Service. In this model, a city, county, or combined joint entity creates an exclusive service area in statute and issues an RFP to contract for ambulance services. Ambulance service companies bid to provide services. The governmental entity typically will set specific performance expectations in the contract and continuously evaluate performance. This model relies on fee-for-service or something else of value in the contract for bidders.

Alternative Model 9: Dual Role/Cross-Trained Providers. Because rural areas typically have low ambulance call volume, and paid personnel are viewed as simply waiting for calls, much attention is being given to finding ways to dual-train or cross-train personnel so that they can perform other functions. Ambulance personnel may work in a health care facility, law enforcement, fire department, or public works department while awaiting ambulance calls.

Currently the dual-role medic getting the most attention is the Community Paramedic or Mobile Integrated Health (MIH) provider. In this role, paramedics are given additional education and training in primary health care and other areas to assess and treat non-emergency patients outside the hospital in the most appropriate manner. Working with organizations such as hospitals, hospices, home health, long-term care, and behavioral health, MIH personnel may:

- conduct home visits to assist patients with chronic disease management or post-hospital discharge follow-up;

- respond and treat in place for minor medical problems;
- transport patients to alternative destinations such as clinics, mental health or substance abuse treatment centers;
- connect patients with social services and other community-based services to ensure they have basic needs met;
- help prevent the unnecessary use of 9-1-1;
- provide telephone advice and use telemedicine to connect patients with resources;
- and act as a general aid in making health care more efficient.

Air Medical Resources

It is important to remember that air medical resources such as helicopters are increasingly more available in rural areas through the U.S. While expensive for the patient, these services provide a valuable and rapid emergency medical transport option to patients in rural and remote locations. When planning your model, it will be useful to identify and meet with area air medical resources to better understand their availability, limitations, cost, and willingness to collaborate.

Evaluate Alternative EMS Models

At this stage, your EMS Work Group may be overwhelmed and inclined to focus on what will not work, rather than take the time to really understand each option and how it may or may not work in your community. It's a common trap to focus on cost and plunge your change process into a quagmire of impossibility.

Instead, consider a more positive approach that values the uniqueness of your community. Solving your EMS problem will take some unique thinking, imagination, creativity, and innovation. Likely you will need to find and create a model that is honed and refined to meet your community's specific needs and location. You may have to convince people who are negative that this new model will work. You likely will have to identify financial resources that you did not know exist. All of this work takes a powerful commitment to finding what is best and thinking outside the usual boxes. Do your best to discuss a variety of models patiently and systematically. Allow your imagination and creativity to work.

As you consider various alternative EMS models, the following attributes and questions should guide your thinking and discussion.

Attribute 1. What do we need, want, and care about? When it comes to the provision of ambulance services in your community, it is important to get clear about what you need, want, and care about. Beyond simply saying, we need ambulance services, want the best we can have, and care about being able to do this with the least amount of cost and anxiety, reflect on the work you have accomplished so far and thoughtfully answer this question.

To find more clarity, discuss the following: What is the specific need in terms of call volume, response time, and transport time? How often will ambulance services be used? What are the risks associated with not having ambulance services? What communities care about shows up in what they invest in and the topics they get passionate about. What does your community care about?

Some additional questions to explore are:

- What do we want and need in terms of being a viable rural community of which residents and businesses will want to be part?
- What level of clinical care do we need and why?
- When it comes to creating quality of life and safety, what do we care about?
- How much time do we reasonably have to implement a new model?
- When is the appropriate and best time to end the all-volunteer model?
- What are the pros and cons of government involvement in the provision of ambulance services?

Attribute 2. What are we willing to pay for? While rural communities may feel the pinch of tight budgets, municipal governments regularly make choices about how to spend revenues. Sustainable ambulance services will demand an investment. With the decline of volunteerism, communities must ask if they view EMS and ambulance services as essential.

With the subsidy of volunteer labor, communities invested very little in ambulance services. Now more investment is required, but only if this service is seen as necessary or essential. If having an ambulance service is indeed essential, how might this be demonstrated? Are residents willing to

fund ambulance services? Are residents willing to have less of other funded essential services such as public works, parks, schools, law enforcement, etc.? These are all key questions to consider as your community asks, what can we pay for?

Some additional questions to explore are:

- What financial resources do we currently have?
- Do we have facilities assets that may be useful in negotiating for services?
- What potential financial resources are within our community and region?
- Do we want ambulance services in our community to be subject to the market forces?
- Which models are the most efficient for us?

Attribute 3. What are the strengths of each model? As your EMS Working Group considers the various models, it is important to consider the strengths of each. For example, local ownership of ambulance services enables the community to have a certain level of control and pride in the services. QRUs are efficient. Contracting for services leaves the details of hiring, managing, and operating services to someone else. Dual-role models may enable the community to solve more than one problem.

Some questions to explore are:

- Apart from finances, what is the best model for our community?
- How might local ambulance service become part of regional health care services?
- Are there primary health care and/or public health care needs in our community or region? How might EMS help with these?
- Are there successful ambulance service models in neighboring services?
- Which models would require the least amount of local oversight and management?
- What are the benefits of viewing ambulance services from a larger, regional perspective?

- If paid staff are needed, are they available in our region? If not, could we attract them?

Attribute 4. What are the limitations of each model? As your EMS Working Group considers the various models, it is important to consider the limitations of each. For example, contracting for services demands local oversight of the contract. Based ambulance service limits local pride and control. First response only leaves patients waiting for the transporting ambulance.

Some questions to explore are:

- How would not having a local ambulance service impact our community?
- Do we have experience and knowledge locally to operate our own paid ambulance service?
- Are interfacility transfers an issue that we need to consider?
- In what ways have regional services (e.g., schools, law enforcement, etc.) not worked in our region?
- Are air medical resources a reliable option for critical medical emergencies in our community? What percentage of the time are air medical services available and able to fly?

Choose the Best Options for Your Community

As your EMS Working Group dives deeply into the above assessment and evaluation processes, several EMS models will emerge as possibilities. Your EMS Working Group should choose one to three alternatives to recommend to your community. These choices will emerge from a careful consideration of all options, the input from experts, financial analysis, your perceived strengths and limitations of each model, and your community's needs and wants.

The horsepower of your EMS Working Group is essential in making the best choices for your community, which will emerge from healthy and robust discussion and disagreement. Each person's perspective matters. All voices should be heard, and the group should continue its discussion and debate with the goal of clear support throughout the EMS Working Group for your

final recommendations. Consensus is not essential, but all dissent should be heard and considered.

Once you settle on your best recommendations, describe each in a document or PowerPoint presentation using “what, why, and how,” as described below.

- What? A full and detailed explanation of the model being recommended. Operational details should be described, including how the model will operate within the regional EMS and health care system.
- Why? Make a compelling argument for why this option is among your best recommendations. Connect each option with the unique needs and wants of the community and the resources that will make this option possible. In constructing the why, consider all of the negatives that may be leveled at this choice.
- How? Provide a clear description of how each option will be turned into a reality. This does not need to have all of the details, but it does need to address the primary issues of leadership, finances, workforce, and operational realities, all accompanied with a proposed timeline.

Step 5. Obtain Community Support for the Change Process

Step 5 is intended to guide your EMS Working Group in sharing your recommendations for alternative EMS models with your community. This guide assumes that your EMS Working Group is empowered to make recommendations (as opposed to making final decisions and implementing a plan without seeking community buy-in). In this case, your recommendations must be sold to two important groups: key community leaders, influencers, and decisionmakers; and community residents at large. Here is how you can accomplish the goal of gaining support, enthusiasm, and commitment for your group’s recommendations.

Present Your Case to Key Community Leaders, Influencers, and Decisionmakers

Hopefully, your EMS Working Group includes community leaders, influencers and decisionmakers. But even if all the key stakeholders have not been part of your working group process, it is crucial that significant cohort of

community leaders support your recommendations. This cohort should be informed personally by EMS Working Group leaders. They should be told that your group is nearing completion of its work. Invite them to a gathering to make your pitch. Be sure to pay attention to open meeting laws, if applicable, and act appropriately.

Your gathering should include a presentation on your EMS Working Group's process, inquiry, and findings, along with your recommendations. The recommendations should be presented using the "what, why, and how" format. The presentation should take no more than 40 minutes, including ample time for discussion. The goal of the meeting is to obtain support and entertain critique from this key group.

If there is positive and majority support for the recommendations, your group can move ahead with its community-wide presentation. If there is significant opposition to your recommendations, your EMS Working Group may want to revisit and augment your recommendations and meet again with the group of leaders, influencers, and decisionmakers until you can find common ground with which everyone agrees. There must be enough support for the recommendations from this group to move forward.

Present Your Case to Your Community

Once there is sufficient support among community leaders, influencers and decisionmakers to move forward, host another communitywide meeting and make the same presentation to community residents. The goal of this meeting is to inform, build support for the recommendations, and answer questions. This meeting is not about having residents vote or fully agree. Issues such as taxing districts that require resident support will be handled down the line during the implementation process. This meeting should end on a positive note with the EMS Working Group demonstrating gratitude to community for their participation in the process.

Step 6. Implement the Change

You have reached your final step – congratulations! Now all you must do is implement the change that you want to see.

Precisely how the change will happen depends on your unique situation. Who will assume ownership for the change, and the organization or entity that

will actually oversee the new ambulance service, is beyond the scope of this guide. Experience with change in rural communities suggests the following considerations.

Expect Resistance

While the intent to change from unsustainable to sustainable ambulance services is to do good, expect challenge, roadblocks, and resistance along the way. It is natural for people to fear change and fight for the status quo – this is actually a natural part of the change process. With change, there is always a sense of loss and grieving. Ambulance volunteers who have found meaning and mission in their volunteering may fight the change, as may people in the community who see the demise of the ambulance service as another sign that the “good ol’ days” are gone and their beloved community “ain’t what it used to be.” Because change always includes loss and acceptance, a valuable way to work with the emotional impact of change is to recognize change as a journey taken in steps. These steps often show up as: shock and denial; bargaining and fixing; frustration and/or anger; discouragement, gloom, and inaction; curiosity, openness, and experimentation; and acceptance, decision-making, and action.¹²

Shock and denial: When encountering the evidence of a failing volunteer ambulance service (inability to recruit enough people, delayed or missed calls), people (especially volunteers) may experience a sense of unsettling surprise and actively deny volunteerism is not sustainable. They may refuse to talk about the possibility of not having volunteers. They may simply act as though everything will be okay. Many ambulance services and communities are in this state of denial. Leaders may also see shock and denial when presenting the full cost and economic value of the local ambulance service.

Bargaining and fixing: In denying unsustainability there is often a long and protracted period of trying to buy time and put band aids on the current volunteer system. Repeated efforts to recruit, host EMR and EMT classes, and get people interested need to occur. Because it is too difficult to fathom anything different, all of the emotional and psychological energy must be

¹² The emotional and psychological change process is often described as a change curve and framed using the work of Elizabeth Kubler-Ross. Kubler-Ross identified five stages that dying patients go through in accepting death. Her observations have been applied to loss and grief as well as organizational and community change. The change steps described here are a variation of Kubler-Ross Change Curve™ and emerge from SafeTech Solutions’ work with change in rural communities.

invested in trying to protect the status quo. This step is essential in moving toward the recognition that change is needed.

Frustration and/or anger: As the ambulance service continues to struggle in an unsustainable state and fixing is not enough, strong expressions of emotion such as frustration and even anger should be expected. Beneath the frustration and anger is usually fear. Volunteers and local residents are afraid that the security and safety provided by the ambulance service will disappear. They are afraid that the pride, identity, and sacrifice they have made over the years will be lost. And, indeed, this is a huge and monumental loss for the volunteers and the community. The strong emotion should be expected and needs healthy expression. This is normal and leaders should allow people to mourn what is being lost.

Discouragement, gloom, and inaction: On the way to accepting change there will be a period where people will begin to accept the unsustainability of their volunteer service, but not yet see the possibility of something new. This time is often characterized by heavier feelings. These feelings may include a sense of deep discouragement, failure, hopelessness, and gloom. During this time people may express sentiments such as, “what’s the use?” and “it’s never going be like it was?” In this phase, any fixing stops. People may stop attending meetings or curtail their involvement. This is evidence that the emotional attachment to what was is being acknowledged and grieved.

Curiosity, openness, and experimentation: As people come to accept the inevitability of change, curiosity often awakens. It may start with a desire to learn about how other communities have moved beyond volunteerism. It may show up as a willingness to plan, participate, or simply listen. This is an important step in which leaders should be prepared to present possibilities and talk about hope. Discussing a variety of options helps people regain a sense of agency or control and begin to experiment with what might be. The leader’s role here is not to prescribe a single solution but to engage people’s imagination of a hopeful future.

Acceptance, decision-making, and action: As people accept the necessity for change, grieve what is being lost, and begin to see hope in the future, they can complete the change journey and make decisions. This never comes all at once but is a gradual process. The leader’s role is to ensure that there is wide acceptance and buy-in to the way EMS and

ambulance services will look in the community in the months and years to come.

Change takes time. The steps described above may not occur in a perfect linear fashion. The process of change can be messy. Build in time and space in your change process to accommodate the necessary grieving of what is being lost and the uncomfortableness that comes with considering something new. Take time to listen to people and allow for the expression of emotion. Resist the desire to silence strong feelings, especially when they differ from your own. Ensure that the change timeline is well-managed and has a balance between getting things done and not moving too fast.

Leadership is Key

Strong leadership is a key ingredient to making change. The person chosen to lead your change can make or break the process. Carefully chose a leader who believes in the change, can be decisive, can influence, and, at the same time, is skilled in working with the resistance. These abilities are more important than EMS knowledge and experience.

Take Small Bites

Implementing a new model for ambulance services is a huge undertaking. At times, it all will seem too big and difficult. You will not have all the answers at the beginning. You will encounter unexpected challenges. You will likely need to create and develop things that have not been done before. All of this will require simply focusing on the next small bite.

Organize your change plan into a series of small objectives. For each objective, describe clear tactics and actions. Then make sure someone owns those tactics and actions and is appropriately resourced to accomplish them in the allotted timeframe.

Appendices

Appendix A: Leading Rural EMS Change

Creating sustainable ambulance services requires leadership. Many rural communities acknowledge the decline of volunteerism, as well as the emerging need for change and the development of sustainable models. However, often there is no action. The prime reason for lack of action is lack of leadership. A capable leader or group of leaders is needed to step up and lead any sort of major change. Without leadership, proactive change is unlikely if not impossible.

Leadership is the ability to influence others in a direction. The call for leadership can be seen when there is a crisis or things need to change or be improved. Yet becoming an agent of change and influencing others in a rural community presents significant challenges. The rural mindset tends to be independent, self-sufficient, and inclined to prefer the status quo. Add the drama of an ambulance service that operates more like a club than a business, and the challenge becomes even greater. Fortunately, good leaders are often inspired by great challenges.

Whether the leadership comes from a single person or a small group, work with rural communities through the U.S. demonstrates that leadership success is characterized by the following:

- A belief and vision that things can be better.
 - Leadership always starts with the leader's faith. To garner followers, a leader must have a strong internal persuasion that things can change or be made better. Without that inner conviction, convincing others is difficult. When leaders have faith in the possibility of change or improvement, they can begin to describe the change in a convincing manner and get others to see it. This is the power of a vision.
- Leaders need not have everything figured out or a detailed plan about the what and the how.
 - They must simply see and articulate why change is needed, identify the benefits that change will bring, and tell a powerful story to others about that change.
- A willingness to invest the time.
 - Getting others excited about change or improvement takes a large investment of time. The time investment is in garnering

attention for the change, building relationships with key stakeholders, creating a supportive coalition, listening to others, understanding resistance and other points of view, and explaining the change in the form of a story. Many leadership endeavors fail because of an unwillingness or inability to invest the time.

- The ability to influence.
 - The most compelling evidence of successful leadership is the attraction of enthused followers. Leaders can influence in many ways – through fear, position or title, charisma, holding information or knowledge, or promising rewards. The kind of influence that truly produces results, however, usually comes from a combination of nurturing needed relationships, the leader’s character, and the leader’s ability to inspire people to care about his or her vision. This kind of leadership influence, especially in the beginning stages of any given endeavor, is often built one person at a time.
- The curiosity and maturity necessary to learn from others and mistakes.
 - Effective leaders do not need to have all the answers. But they need to be curious and humble enough to learn from others. The specific solutions for your community will emerge as those who lead try things, fail, learn from mistakes, and continuously seek input from others while borrowing from what works.
- A willingness to enter the political arena.
 - To lead change in rural communities is to engage in politics. While politics as practiced in many locations and nationally is fraught with conflict, outrage, and enemy making, these attributes do not define politics. Politics is simply about garnering the power to influence people to get something done. It is about listening, negotiation, and compromise. This can be done ethically and in a manner that is positive and constructive. Truly leading also has risks. To step forward and ask people to depart from the status quo and consider something new may invite critique and judgement. Being in the political arena demands courage, a thick skin, and the maturity to handle criticism.

- Perseverance
 - Leading the creation of a sustainable ambulance services model can take years. It typically takes 3 - 5 years for rural communities to change their ambulance service delivery model. Leaders must be in it for the long haul.

Appendix B: Sample EMS Working Group

First Meeting Agenda

Date

Time

Working Group Member

(list all members by name)

Charge of the Group

As operating today, our ambulance is not sustainable. The charge of the EMS working group is the following:

- Create awareness among community leaders about the current situation and deepen our knowledge about rural EMS, its needs, costs, and sustainability.
- Build community understanding and consensus that volunteerism will likely not be a viable long-term staffing option for our local ambulance service.
- Involve the community in a discussion about the future.
- Ensure current operations are supported and can run safely and humanely for the remaining volunteers.
- Proactively plan for change, including identifying criteria for knowing when to change the way we are operating today (before an adverse event).
- Explore the true and full costs of EMS in our community, including the full cost of labor.
- Identify a menu of options for creating a new era of ambulance service in our community. Use outside consultants as needed.
- Investigate the most achievable options.
- Provide collective leadership for developing and executing an achievable plan.

Note: This work will likely take 12-36 months.

Agenda

Welcome

Introductions (if necessary)

Why We Are Here

As operating today our ambulance service is not sustainable. We are stretched too thin. The remaining members of the ambulance service are good at EMS, but not necessarily good at planning for a new era of ambulance services in our community. This is a community problem, and we need help from community leaders. This committee is about helping our community figure out how we can create sustainable ambulance services for the future. (Review the charge of the committee.)

Background Material

- Discuss the indicators for change (Step 1)
- Discuss the Working Group's authority and empowerment

Discuss Steps for Change

Pass out copies of this guide and review the steps

Choose Committee Leadership

Those running calls in the ambulance service do not have the time nor the leadership experience to lead an in-depth community discussion around the future of ambulance services. We need the EMS Working Group to choose or elect a committee chairperson and vice-chairperson to lead this work.

How we will Work Together

The group will discuss and agree on how they will work together and make decisions and keep confidentiality (as needed).

Next Meeting/Steps

The EMS Working Group will discuss Step 2 and make assignments about the assessment phase.

Adjournment

Appendix C: EMS Working Group Sample Community Letter and Survey

Date

Dear Community Resident:

We are writing to ask you to respond to the enclosed survey about EMS and ambulance services in our community.

As many of you know, the ambulance service is struggling to find and keep ambulance volunteers. Over the past decade, the ambulance service has been unable to replace volunteers at the same rate that they retire or leave. For several years, the ambulance service has faced critical challenges in ensuring enough staff to cover shifts 24 hours every day. A small number of our community volunteers are now keeping these services open. We have come to realize that, in the near future, staffing our ambulance services with only volunteers will not be sustainable. Therefore, we are exploring other options.

To understand the way forward, we have formed an EMS Working Group made up of community residents and leaders. The EMS Working Group is seeking to better understand the challenges of providing EMS and ambulance services and explore options.

As part of this process, we ask that you complete the enclosed brief survey. It takes only a few minutes to complete and will provide us valuable information about your opinions and concerns. Your responses will be anonymous and only an aggregate of survey responses will be shared. The results of the survey and findings of the full assessment will be presented at a community meeting on DATE at TIME at LOCATION. Your input at this stage ensures that your views and opinions are represented in the process.

Thank you for your time.

Sincerely,

(Signed by the EMS Working Group leaders)

EMS Working Group Resident/Household Survey

Please respond to the following questions. Each question allows for comments that will be carefully read and considered. After completing, please return in the enclosed self-addressed, stamped envelope. Thank you.

1. In the past 10 years, have you or a family member used the volunteer ambulance services in our community?

- Yes
 No
 Don't know

2. Were you aware that the ambulance service is having significant challenges finding and keeping volunteers who are regularly able to staff the ambulance?

- Yes
 No

Comments:

3. How do you view having ambulance services in our community?
(Choose one.)

- Essential (critical to our community)
 Nice to have
 Not needed
 Do not care either way

Comments:

4. If we do not have local ambulance service in the future, would it be acceptable, in an emergency, to wait ____ minutes for an ambulance from outside our community?

- Yes
 No

Comments:

5. In the future, keeping ambulance services in our community will likely require more funding for paid staff. Please indicate your willingness to provide financial support. (Choose all that apply).

- I (we) would be willing to pay more taxes.
- I (we) would not be willing to pay more taxes.
- I (we) would be willing to pay an annual fee to help fund this service.
- I (we) believe ambulance service should be paid for exclusively by people who use it.

Comments:

6. Help us better understand how you view EMS and ambulance services by choosing all of the following that true for you?

- In living a rural community, I (we) expect less services and do not expect EMS and ambulance services to be provided.
- I (we) view EMS and ambulance services as a vital public service that our community must support.
- EMS and ambulance services are as important as public works, law enforcement and schools in our community.
- Government should not be involved in the provision of EMS or ambulance services.

Comments:

7. Do you plan to attend the upcoming community meeting on EMS and ambulance services in your community on (insert date) at (insert time) at (insert location)?

- Yes
- No

Comments:

Appendix D: Resources for Alternative EMS Delivery Models

Below are resources that may be useful when considering alternative models of EMS delivery.

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