EMS IN CRISIS

How do we Keep Things Going?

STRATEGIC
MANAGEMENT & CONSULTING

WISCONSIN OFFICE OF
Rural Health

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PURPOSE

This document is a resource Tool Kit for the purpose of establishing a step-by-step process for an EMS agency that is having difficulty being able to respond to 9-1-1 calls. The inability to maintain a staffing model that provides enough staffing to respond to emergency calls is an issue in many areas in the State of Wisconsin. Descriptions of the issues associated with not being able to respond to 9-1-1 dispatches, how to move a service from totally volunteer to some sort of a paid model, steps for how to cross-credential with neighboring services, and finally the process for merging, consolidating, and sharing resources will be followed by steps on how to fix a number of the problems. Additionally, a list of resource website links will be interspersed throughout the tool-kit for the purpose of exposure to other outside options that may be integrated into your service. The intent is for the Service Director to utilize the various options available, as solutions for an EMS agency to be successful and survive.

This Tool Kit is divided into the following sections:

1. History of Volunteer EMS
2. What caused the Problem to Spin out of Control?
3. What are some Options to Consider?
4. What are the Next Steps?
5. How to Keep the Doors Open to the Ambulance Service
6. Cross Credentialing
7. Shared Resources, Affiliation, and Merging
8. Converting to a Paid Service

HISTORY OF VOLUNTEER EMS

In the past, volunteer ambulance services thrived, especially in rural communities where pride and volunteerism were strong. However, a downturn in the economy and increased demand for quality health care has changed the business model for rural EMS providers. It's all about resource limitation, which is one of the determining factors on whether a volunteer service can provide the level of care that a community wants or whether a volunteer service has the funding necessary to provide that care.

Young families hit hard by the recession were the backbone of many volunteer services. A 2011 national EMS assessment showed that 70 percent of EMS providers, volunteer or professional, were between the ages of 20 and 49. Demographics (of rural communities) have dramatically shifted: there are more two-income families that are dependent on the additional funds to make ends meet; young people are moving away to urban areas for jobs, or commuting to those urban jobs, leaving less time for volunteering.

Unfortunately, there are fewer and fewer people that are interested in filling the void, within the volunteer EMS community. In recent years, many studies across the country have attempted to figure out a solution to the EMS staffing problem. A study performed by the North Carolina Rural Health Research & Policy Analysis Center brought to light many of the issues faced in North Carolina that could easily be expanded to encompass the entire nation. According to this research, only 50% of EMS services in 2008 were fully staffed, of which, more than 63% had a volunteer component as part of their staffing level. These statistics alone showed the need for change in the EMS system. Since 2008 the problem has grown significantly—with services actually closing their doors. How do we ensure adequate staffing and retain the employees, both career and volunteer? That is the question being asked in most every rural area in Wisconsin.

The standard in the EMS industry for gauging adequate response to an incident is the response time. The National Fire Protection Agency recommends that BLS first response providers arrive with an AED on scene within 4 minutes and ALS providers arrive on scene within 8 minutes. While there is current debate on whether or not these response time guidelines are appropriate, the argument can easily be made that the quicker trained personnel arrive on scene to help mitigate an emergency situation, the better the outcome of that situation. The ability of a service to provide trained personnel to mitigate the emergency is directly related to the staffing levels and call volume each agency is responsible for.

What Caused the Problem to Spin out of Control?

The modern EMS System began to take shape in the U.S. during the 1960s following the publication of a report titled "Accidental Death and Disability: The Neglected Disease of Modern Society," by the National Research Council. As we progressed through the 1970s and ’80s, Americans were provided pre-hospital care by trained members of local ambulance providers, police or fire departments. Throughout the late 20th century, many developments in medicine and emergency medical care created the need for additional training, certification and continuing education for pre-hospital providers.

With these industry developments, volunteer EMS agencies began to decline as volunteer members found it difficult to meet these new requirements. When asked about difficulties retaining personnel, more than 65% of respondents reported that time and scheduling conflicts contributed to retention problems. Agencies with operational authority over these EMS entities began incentive programs to keep volunteers while pushing for state tax breaks for volunteering and even hiring supplemental career personnel to provide the necessary service to the community. These initiatives have helped slow the shortage but did not prove to be a definitive answer.

It is important to understand why people are leaving or have left the service. Usually, people don't leave EMS because they don't like the work any longer…they leave because of life changes, or sometimes a person or a group of people. Personality conflicts can do more damage to an active EMS service than anything else. So, you need to ask people when they leave, why? It is interesting to see that when a troublemaker is removed, how many of the past members are interested in returning to volunteer at the Service. Policies within a service must be written so that it is unacceptable for service members to bully, ridicule, or otherwise damage the reputation of a fellow member.

Volunteers are aging. People are moving to or working in urban areas, making it inconvenient for them to volunteer for a rural service. The changing face of the country's economy has also made it more difficult for people to volunteer. Many jobs do not offer the flexibility for workers to go off the clock for a few hours to attend to their volunteer duties if there is an emergency, and in the wake of the financial collapse, some workers are balancing multiple part-time jobs to make ends meet. The days when a small-business owner, such as a local mechanic, could be on-call and place a "closed for emergency" sign in the window are all but gone. It is really changing the dynamics, and certainly the economy has a lot to do with this. We've built this system for 30 years on the shoulders of volunteers, and now we're having a tough time trying to turn that ship around. Most experts agree that the future of EMS will be a mix of paid professionals and volunteers, with the number of paid EMTs likely increasing over time.

The younger generation that is replacing the older EMS provides do have an interest in volunteering and/or working in EMS. The issue is that their interest is short-lived. It is now recognized that even in the business world, most employees only stay with their employer for an average of 2.7 – 3.0 years. At that point, they might even move on to a totally different career or interest. That has changed the mindset of recruitment and retention. Whereas an EMS agency counted on volunteers to stay with the ambulance service for 10 or even 20 years, the new expectation is that there will be an employee turnover on the average of once every three years.

Lastly, we have to recognize that there is a great amount of pride at the local ambulance service—in providing EMS to the community that it serves. Though the pride of the service helped in the recruitment of volunteers in the past, it can now actually become an obstacle, creating an environment in which a number of problems are developing:

1. The service may not see or be in denial that they are in need of additional staffing.

2. Even if the service realizes that they are short-staffed and being paged three times to respond to an emergency (or are missing calls entirely), they might refuse to call assistance / mutual aid from surrounding ambulance services, to assist when needed.
3. The service spends scarce funds on a “reserve” rig that is rarely used throughout the year.

WHAT ARE SOME OPTIONS TO CONSIDER?

The first possible answer to the problem of the staffing shortage is to increase monetary incentives for employees and members of the Service. The lack of adequate compensation for the hard work that the crew members perform is part of the complaint contributing to difficulty retaining personnel. With increased pay, employees would be more likely to stay in the profession. This will help to retain the current providers, recruit new providers, and close the gap on the current staffing shortage.

In certain areas of the country, volunteers are compensated monetarily once they hit a certain response volume or number of hours volunteered. In North Carolina, more than 30% of providers are compensated by some payment method for the service that they

provide. The time that the emergency responders give to the system is very valuable and they should be compensated for it. That said, implementing plans to expand compensation to EMS providers is difficult in the current political landscape. Citizens are unhappy paying additional taxes and seeing too much of their salaries already being taken by the government. In addition, it is hard to tell someone to pay more for a service that they may never use.

An additional method of closing the gap on the current shortage is to combine EMS into existing emergency roles. Currently across the country, members of police and fire departments are trained in basic first aid, CPR, and AED usage. This provides for the necessary first response to the scene of an emergency. By cross training the local emergency personnel to provide a higher level of medical care (perhaps even ALS interventions) it will enable a highly trained provider to be on the scene much quicker than waiting for the responding ambulance. Once again, the cost of providing such a service and training through additional emergency services has become burdensome.

Some agencies that have already had their foundations in fire or police service for decades refuse the notion that they should be part of EMS, and they may resist the incorporation of such tactics into their departments. In addition, the risk of a police or fire unit being tied up on a medical call when it may be needed at another location for a police or fire emergency could potentially cause significant harm to the second caller in need.

Many ambulance services have lost service members because of childcare responsibilities. The EMS providers love being part of the ambulance service but don't have a babysitter when the pager goes off. How about developing a program of trustworthy individuals in the community that can leave their home at a moment's notice.

Those people could carry a pager, just like the EMS personnel and when the pager goes off, they respond to the station and open the day care center. This allows for those previously unable to respond to now respond. They can bring their kids knowing that someone will be there or on the way, and their children will be well taken care of while they are responding to EMS emergencies. These "Childcare Workers" would be just as much a part of the service as those who respond to the calls.

WHAT ARE THE NEXT STEPS?

The crisis that we have found ourselves in didn't occur overnight. Sadly, while many were professing that an EMS Workforce shortage was looming on the horizon, many felt that this was crazy talk, and comfortably placed their heads in the sand. Because the issue didn't occur overnight, it is unlikely that a solution will be developed overnight.

The service delivery models of the past will be inadequate for the future. EMS Providers will need to embrace other models for providing services. Some of those "other models" can be considered from the list below:

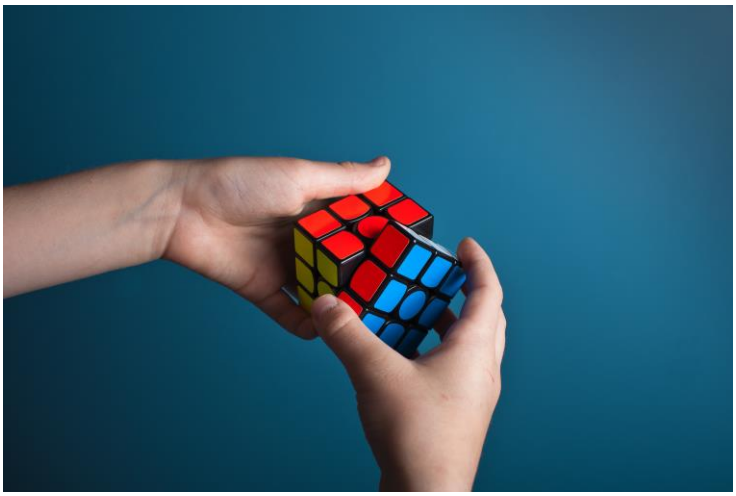
1. Cross Credentialing with a neighboring EMS provider.

2. Enter into a consolidation agreement that recognizes the services that have consolidated and are now part of an EMS District.

3. Develop incentive programs.

4. Review and restructure pay schedules that are attractive and will entice individuals to your service.

5. Consider a benefits package that can be built on from year to year.
6. Consider a paid on-call system.
7. Consider limited part-time status employees.
8. Consider fixed schedule part-time status employees.
9. Consider part-time – full-time combination staffing models.
10. Consider an all full-time personnel system.



How to Keep the Doors Open

Example: "We started having occasional days when parts of our schedule had some holes, but we were always able to cover the call if we had one. Then the holes started to become more frequent…for the most part, we were still able to cover the calls when paged. Now we have many days where large blocks of time are not covered, and we are relying on mutual-aid to cover our service area".

The link below will direct you to a site that will outline the Emergency Medical Services (EMS) Recruitment and Retention Manual produced by the Federal Emergency Management Agency and the United States Fire Administration.

EMS Recruitment and Retention Manual

~How townships can help EMS:

Most township officials are not knowledgeable in the EMS field and don't understand the cost of operation and the problem of low reimbursements. Therefore, it's important to educate them. Having an elected official serve as the champion for EMS can be helpful, too. When a meeting is called to look at the financial problems with the EMS service, make sure that all the municipalities that you provide service for are present. Offer to go to them and made a presentation at their public meeting. In most cases residents who were in the audience were completely unaware of how difficult it is to maintain services.

Getting these residents to understand the problem can be extremely important to sway their municipal officials to act, to ensure the survival of this life-saving critical service. When townships recognize that there are problems, many supervisors step up and can perform the roles of communicators, fundraisers, public relations specialists, and grassroots advocates, all areas that can help keep EMS organizations running. Below are some ways townships might be able to assist their local EMS providers:

• **Find out what they need** — Meet with your EMS providers on a regular basis to find out their needs and how townships can help.

• **Consider funding options** — Make a regular contribution to EMS from the general fund or collect an emergency services tax to provide an annual source of income. Townships may also dedicate up to half a mil rate of township taxes to such services.

• **Check out state contracts and in-kind options** — Help EMS providers secure emergency medical equipment and other items through statewide purchasing contracts. Help the EMS provider learn how state and federal government surplus programs that are available and how they work. In-kind contributions can also be invaluable, noting that EMS could save money by piggybacking on municipal fuel purchases at a lower rate.

• **Help with grant searches and grant writing** — Use your township's experience with grants to show the EMS service where to look for grants or how they may be able to share, such as the state Department of Community and Economic Development (DCED) and other state and federal agencies, and offer pointers on how to write successful proposals.

• **Support ambulance memberships and fundraisers** — Become a member of your EMS service and encourage your residents to do so, too. Support any community fundraisers that would benefit the local EMS and fire companies.

• **Recruit volunteers** — Put out the call for EMS volunteers and provide incentives to volunteers, whether it's offering free membership to the community pool, the local YMCA (or similar venue) or implementing tax credits.
There currently (2019) are several programs being introduced by the State Legislature to allow townships to offer earned income and local property tax credits and rebates to qualifying, active volunteer EMS providers.

• **Contact your legislators** — Alert your legislators to the problems facing EMS agencies and advocate for legislative changes that will improve their plight. Examples include increasing the Medicaid budget to provide a more equitable reimbursement level similar to what EMS providers receive from Medicare and third-party insurers for medical assessment and treatment even if no transport occurs.

• **Become an EMS champion** — Be an advocate for EMS, cheering on the invaluable service it provides to your community and spreading the word about its needs. Everyone who is a member of the service doesn't necessarily have to respond to the actual call. Be creative in seeking residents to be part of the service.

- Find people who are local mechanics who may have an interest in the light maintenance of the vehicles.

- There are many retired people who are still looking for ways to be active. They can become part of the service and provide valuable services to a local EMS provider. Examples include:
  - Former personnel managers
  - Former purchasing managers
  - Former bankers
  - Former finance managers, accountants, or bookkeepers
  - Former grant writers
  - Building maintenance personnel

In general, a large number of EMS providers are not-for-profit entities. While this allows them to perform services without paying federal, state, and local taxes, too often these agencies fail because they do not follow a proper business model. Without necessary oversight and a business background, leaders of the smaller not-for-profit entities are unable to form a consistent business plan that ensures survival and adequate levels of readiness.

The following links will provide additional information with resources that will help you navigate the issues that we are all now facing.

WI Department of Administration - Service Award Program

WI DHS - High School EMT Course

WI DHS - Apply for a Local Credentialing Agreement

WI DHS Rule 110.52 - EMS Personnel Credentialing

WI DHS Scope of Practice

WI DHS Service Licensure

WI DHS Service Licensure and Operational Plan

CROSS-CREDENTIALING

Example: "I was approached by the service next to us, as they were having trouble covering calls during the daytime. He said he noticed that we were having the same issue. We know each other well and understand both of the service areas. We also know we have members of our service that work or frequently visit or shop in the other service's community. We started to talk about the value of utilizing each other's members to respond to calls when available, while we were in the other community. So, we decided to cross-credential many of our members so that they would belong to both services and would legally be able to respond to calls. We had to work out the details like training, eligibility, insurance, etc. but it was well worth the effort. Since we completed the change we are able to cover our areas."

The concept of cross-credentialing is one that doesn't come to mind immediately for many services. Even though many EMS personnel live in a town in which they volunteer with the ambulance service, they may actually work in a neighboring town, or they may travel through it frequently.

One of the ways to deal with shortages in both of the ambulance service areas would be to "credential" members to each one of the neighboring services. This in effect doubles the roster for each service—and it increases the ability to respond to emergency calls that are now being delayed or not answered at all.

The process for cross credentialing is not difficult, however the ambulance service needs to complete several steps to assure that the individual EMS providers, the service, and the patients are protected.

The steps outlined below are essential to making cross-credentialing successful:

1. Review the roster of the neighboring community that you are considering combining resources with. There may be reasons that not all members of the neighboring service are a good fit for your service. Be sure to discuss this at the beginning of the discussions with the other ambulance service.

2. You need to send an amended “Operational Plan” to the State EMS office describing the change to the operations, with an explanation of what you are planning to do, how you are going to do it, and the expected impact of making the change.

3. You should also consult with your service’s Medical Director to assure that they will approve of the person(s) that you want to credential to your service.

4. You will need to check that the individual(s) are in compliance and not on the OIG Exclusions List (see link below). Note: you should be checking this list at least once per year, for every member of your service.

5. Once an individual has been selected, and they meet all licensing requirements in DHS 110.06, they can now be credentialed with your service, based on their WI EMS license. The individual should log into the WI EMS e-Licensing system and apply for a local credentialing agreement with your service. (See link below.)

6. Require copies of the individual’s certifications. (E.g.: CPR, ACLS, etc.)

7. The two services that are considering sharing resources may be at different service delivery levels. (E.g.: ALS vs BLS or Critical Care, etc.) Each service provider needs to assure that when using shared personnel, the specific service delivery models are maintained. (Example: Service 1 needs an AEMT, but Service 2 is a BLS service.)

8. You will need to revise Medicare form CMS-855 with the details and submit a new member roster. (See link below.)

The following links will provide additional information with resources that will help you navigate the issues that we are all now facing.

WI DHS Operational Plan

WI DHS Local Credentialing Agreement

WI DHS Rule 110.52 - EMS Personnel Credentialing

WI DHS Scope of Practice

WI DHS Service Licensure

OIG Exclusions List

Medicare Form

SHARED RESOURCES, AFFILIATION, AND MERGING

Example: "We have tried paying our people, cross-credentialing, adding part-time paid staff and we are still having trouble. We are very proud of the service! We have been doing this for 30 years! However, it was time to start to discuss what to do next, because what we are doing now isn't working. I called the Service next door; I know that they are having the same problem. They are just as proud of their Service as we are of ours. We started to discuss the idea of combining our Service with theirs, what that would mean, and all of the other things that would go along with it. We quickly realized that task was more complicated than us just sitting around and talking about it. We had to go to our municipal board for approval, establish an intergovernmental agreement, discuss sharing our assets, sharing our costs, etc. Happy to report that after 6 months of working cooperatively we were able to get it done! I don't know if it is the final fix, but this arrangement will allow us to operate successfully well into the future."

There are three areas that can be considered, when determining how to assure that there is enough staffing, vehicles, and supplies to guarantee that an ambulance can respond to an emergency call at any time in the day: Shared Resources; Affiliation (Cross-credentialing); and Merging.

~Shared Resources: It is certainly appropriate for a Service to plan for the use of an additional rig, when there happens to be multiple calls at the same time, or for when a

rig needs to be pulled out of service for maintenance or repairs. With that said, is there really a need for every ambulance service to have a “reserve” rig in their fleet of vehicles? It might be beneficial, and would certainly save in costs, if two or three ambulance services could pool their funds together to purchase one reserve ambulance to share between their agencies, throughout the year.

A scheduled maintenance plan could be adopted between the agencies, in which the main rigs of the participating agencies are scheduled for maintenance / repairs such that the reserve rig can then be moved from station to station as it is needed.

Additionally, that shared rig can be utilized by the departments when another rig is needed on an emergency call, or it could be used at a standby event, in the response area that is covered by the Services that are collectively sharing that resource.

Another area to consider on the topic of Shared Resources is that of purchasing equipment and supplies. Every ambulance requires a minimum amount of equipment and supplies, which needs to be replenished / replaced over time, and there is a set cost to those purchases. However, if several Services decided to partner together when making those purchases, they could negotiate a lower price from the vendor, which ultimately saves funds for all the Services involved in sharing their resources.

~Affiliation (Credentialing / Cross-credentialing): This topic has been mentioned earlier, but it bears repeating in this section—as it can be one of the quickest, most efficient steps that a Service can enact, to assist with staffing shortages. Staffing is one of the biggest challenges in the world of EMS, regardless of the level of the ambulance service, or whether they are volunteer, paid-on-call / per call, a combination department, or a career department. There are many reasons as to why there is a current staffing shortage, but suffice it to say that all ambulance services are being affected by the lack of EMS providers, directly or indirectly.

Wisconsin DHS 110.52(4) states that, “A certified first responder or licensed EMT may be credentialed by more than one emergency medical service provider.” This Rule allows an EMS provider on one ambulance service to be able to Credential (or Cross-Credential) with another ambulance service. If there are two or more ambulance services that determine that they have similar staffing needs, their leadership can proactively meet to work out a plan / schedule in which the EMS providers can be

utilized across the schedules of the participating ambulance services—in order to provide the best coverage possible. The online credentialing process has been streamlined to such a point, that with just a little coordination between the EMS provider, the Service Director, and the Medical Director, an EMT or Paramedic can be credentialed with an ambulance service in a matter of minutes.

Coordinated efforts by the Service Directors of the participating ambulance services can help to identify when one Service may not have enough staffing on a given day, or time period—and another service can then assist with providing staffing during those identified time periods.

~Merging (EMS District or County-wide): Two or more services that are experiencing staffing, vehicle, equipment, or funding issues could consider merging together into one entity. Other names for this include Consolidation, Districting, and Regionalization. Regardless of which word is used, the purpose is the same: To create a more stable and efficient Ambulance Service that is able to respond to emergency calls in a timely manner. The agencies that wish to work together in this capacity would need to meet and negotiate an agreed upon consolidation agreement that recognizes that the individual Services have consolidated, and are now part of an EMS District.

Items that will need to be considered as part of the consolidated District are:

- **Leadership –** Who will be in the various positions on the Management Team?

- **Medical Direction –** Who will be the Medical Director?

- **Station Locations –** Are the current stations appropriately placed, to assure the best response times within the District? Should a more centralized station be considered?

- **Municipalities –** The elected officials from the Cities, Towns, and Villages will need to be involved, to gain their support for the project—as well as their ultimate approval of the consolidating taking place.

- **Licensing and Operational Plan –** All changes occurring will need to be approved though the State EMS Office, including the entity name, geographical response area, level of service to be provided, staffing, Medical Direction, and protocols / guidelines.

- **Billing Aspects –** Updates may be needed for banking institutions, Medicare / Medicaid, and other insurance payors, as well as consideration of maintaining or obtaining a new National Provider Identifier (NPI) number for the newly consolidated ambulance service.

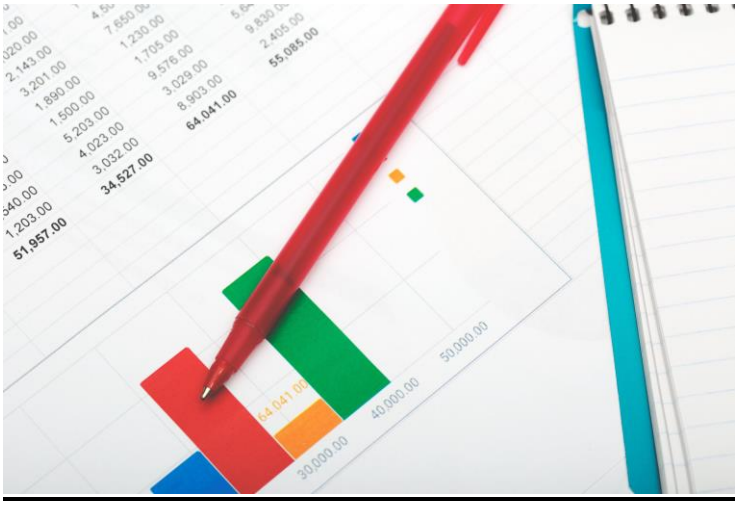
The following links will provide additional information with resources that will help you navigate the issues that have been discussed in this section.

WI DHS - Apply for a Local Credentialing Agreement

WI DHS Rule 110.52 - EMS Personnel Credentialing

WI DHS Service Licensure

WI DHS Operational Plan



CONVERTING TO A PAID SERVICE

Example: "I have done everything I can think of to get more people. We added on to our building and put in a staff lounge, so that people had a place to hang out. We offered to stock the refrigerator with groceries so they would have food to prepare while they were at the station. We started to pay people $5.00 per hour, just to carry a pager and respond. We upped that to $7.50. We then started to pay $10.50 per hour to cover certain periods of the day. All of those things worked for a while. However, after time each option ran its course and we were back where we started. We now have hired permanent part-time staff in hopes that this will provide for stable staffing for the near future. We are now researching what changes would need to take place to provide a full-time staffing model. This is very difficult for our small community to deal with; there just isn't enough money to cover all of the needs of the community!"

When considering the various factors that are needed to convert from a volunteer to a paid service, it is best to plan a step-by-step progression, that addresses the immediate concerns of the service—and is flexible enough to adjust as the needs of the service change. The service may convert to a full-time/career staff in a matter of months, or they may take years progressing though the steps of beginning with an entirely volunteer crew, to end in a staffing model that can easily be maintained by the organization.

The two driving factors for how fast a service converts from one model to another will be based on: (1) the need to cover open shifts on the ambulance schedule, and (2) the funding available to pay the employees for their time and service.

Each ambulance service will have different times that are difficult to cover, based on factors such as the type of community (Rural, Suburban, Urban, or Bedroom); the number of staff on the roster; and if the staff have other full-time jobs in that community, or outside that community. Some services experience staffing shortages during the daytime hours, some have difficulty filling the schedule on the weekends, and some have shortages at night. Regardless, the staffing shortages typically cause an ambulance service to consider paying the volunteers to be available during those hours that are difficult to schedule.

The most common type of transition is to pay the volunteer “Per Call”. That is to say, for every call that the volunteer responds to, they would get paid a stipend for each event. It may be $10, $20, or $30 for each response, based upon the anticipated amount of time that the volunteer would spend responding to the call, taking the patient to the hospital, returning to the station and getting the rig in order for the next call—including writing the Patient Care Report (ePCR).

A similar type of transition is to pay a volunteer to be “On Call”. The volunteer usually commits to being within a specific response-time of the ambulance station (usually 5 minutes or less) and will respond to any pages for emergency calls during the times that they commit to being on call. In return, the volunteer is paid a specific amount per hour, for each hour that they are on call. This option can easily be combined with the above option, in which a volunteer can be paid both to be on call for so many hours on the shift schedule, and they could also be paid a stipend for each call that they respond to.

The next step in the process would be to consider a “Paid on Premises” option, which specifically requires that the volunteer be on the premises of the ambulance service, for the time that they commit to covering on the ambulance schedule. This option would typically pay a higher rate per hour, as compared to the “On Call” option, since the service is requiring that the volunteer physically be at the station, while covering the shift schedule.

As the service evaluates the effectiveness of covering the shift schedule with the On Call / Paid per Call / Paid on Premises personnel—while also factoring in the related costs—they may determine that the next step is to hire part-time personnel to assist with filling in the open shift schedules. The service can consider limited part-time staff or fixed-schedule part-time staff. The number of open shifts, along with the available

funds for payroll, will determine how the service proceeds. The part-time staff will be paid a specific amount per hour, which must be at or above the current minimum wage per hour.

Lastly, if the needs of the service indicate that additional staffing is required, the agency will need to consider hiring full-time staff to fill in the slots on the schedule that are regularly open. The full-time employee can be partnered with the volunteer/part-time staff, to ensure that the schedule is properly filled. This step will take some pre-planning to assure that enough revenue is coming into the service to be able to support the additional costs associated with full-time staffing.

The full-time employee will be paid a specific amount for each hour worked, and then if they work more than 40 hours in a week, they will have to be paid at time-and-a-half for each hour over 40 hours. In addition, many services offer a benefits package to full-time employees. Most services will plan to budget for an additional 30% for benefits, above the wages earned by the full-time staff.

The majority of services will most likely remain at some type of Combination Department—they may have a combination of volunteers, On Call / Paid per Call / Paid on Premise personnel, part-time staff and/or full-time staff. Regardless of which type of model they utilize, the service should continually evaluate the need to cover any open shifts in the staffing schedule, as well as fitting a budget that can afford to provide consistent coverage, 24 hours a day, 7 days a week, 365 days a year.

The links below offer more insight to understanding and consideration of various solutions.

EMS1 - Redesigning Volunteer EMS

EMS1 - 4 Ways to Manage a Thriving Volunteer EMS Organization

EMS World - Can Paid and Volunteer EMTs work Together?

This tool kit is not intended to be an all-inclusive exhaustive list of solutions. Every service will have mitigating circumstances that may change deployment strategies. Understand that you are not alone. There are many people in the EMS industry that are willing to assist and mentor those service directors that are in need of some assistance.