# EMERGENCY MEDICAL SERVICES IN THE 21ST CENTURY: STRENGTHENING OUR PRESENCE IN THE FEDERAL GOVERNMENT

## A Position Statement of the International Association of Flight Paramedics

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### Background

In 1966, a National Academy of Science white paper entitled *Accidental Death and Disability: The Neglected Disease of Modern Society*,[1] identified weaknesses in emergency medical services (EMS) and made a number of recommendations to improve care and chart the growth of prehospital medicine. The evolution of EMS since then has been nothing short of a revolution. Basic first aid attendants and minimally equipped ambulances have been replaced with Emergency Medical Technicians and Paramedics who use state-of-the-art equipment and perform timely, critical care interventions to reduce morbidity and mortality. The International Association of Flight Paramedics (IAFP) represents over 1,000 experienced paramedics who function in a high performance environment beyond the dreams of the 1966 committee. Thus, the IAFP is a key stakeholder in the future of EMS.

September 11, 2001 forever altered our frame of reference in terms of public safety, emergency preparedness, and domestic response to terrorism. The impact on emergency health care is enormous, including mass casualty treatment; medical management of chemical, biological, nuclear, radiological and explosive agents; personal protection and facility security. The creation of the Department of Homeland Security (DHS) was a substantial change in the federal government, combining many government agencies. This new department is the focus of vast amounts of Congressional funding to assure a state of national readiness. However, virtually all DHS funding has gone to law enforcement and fire services.[2] Similarly, the Department of Health and Human Services (HHS) released its "Record of Accomplishment" in biodefense spending in April 2004. Public health, hospitals and food safety were notably addressed and funded, yet EMS was not even tangentially mentioned.[3]

In December 2004, New York University's Center for Catastrophe Preparedness and Response held a roundtable with numerous EMS-related organizations. Many attendees are affiliated with "Advocates for EMS" (AEMS), a not-for-profit organization led by the National Association of EMS Physicians, the National Association of State EMS Directors and the National Association of EMS Educators.[4] NYU's information report, *Emergency Medical Services- The Forgotten First Responder,*[5] identified numerous shortcomings in homeland security resources for EMS. This group concluded that existing federal offices should remain as is, and a Federal Interagency Committee on EMS (FICEMS) is the best solution to coordinate their efforts.

On May 2, 2005, the George Washington University's Homeland Security Policy Institute (GWU) released an issue brief entitled *Back to the Future: An Agenda for Federal Leadership*

*of Emergency Medical Services.*[6] In it, the Institute's Task Force on Emergency Medical Services exhaustively described the history of EMS, its funding and evolution. They also articulated the relative absence of EMS as a homeland security priority. In contrast to the NYU group, GWU built a substantial case to create an independent U.S. Emergency Medical Services Administration in the Department of Homeland Security.

## Discussion

As EMS has matured, it has remained in the public safety shadow of fire services and law enforcement. Both the NYU and the GWU reports highlight how EMS has remained underfunded while the demand for its services has grown dramatically. While fire-based EMS exists in many areas of the country, fifty-five percent of emergency medical services are provided by private, third service, hospital or other providers.[7] The vast majority of air medical and ground critical care transport services are run by hospitals, non-profit or for-profit agencies. These providers, regardless of their affiliation or financial structure, are first line responders. In spite of this, these private entities are largely excluded from grant programs developed since 9/11 to improve preparedness. Further, such providers must enhance their capabilities while facing steadily decreasing reimbursement from Medicare, Medicaid and third party payors.[8] [9] In this context, it is increasingly difficult for non-governmental EMS agencies to continue current services, much less expand them. Enhancing preparedness without grants or improved reimbursement is unrealistic. Since the majority of our membership comes from these organizations, the IAFP considers this to be a significant and perilous safety issue.

EMS has a multifaceted role: as essential public safety responders, side-by-side with fire and police; as an out-of-hospital component of the health care continuum; and as public health providers. As such, there are numerous federal Departments that have complimentary objectives with the EMS mission. However, all of these Departments have such a broad scope that EMS receives little, if any priority. The EMS program office in the Department of Transportation-National Highway Traffic Safety Administration (NHTSA) appears to have the most prominent EMS role in the federal government, yet their involvement stems from the formative years when EMS was primarily linked to automobile crashes. They have made progress, but NHTSA's focus diverges from the evolution of EMS. Department of Health and Human Services programs have a substantial impact on EMS, especially since the Centers for Medicare and Medicaid Services are health care's largest payors. The Health Resources and Services Administration funds several limited focus EMS-related grants. This being said, it may seem logical that EMS, and by extension a U.S. EMS Administration, would best fit in HHS. However, the expansive responsibilities of HHS, particularly with managing Medicare and Medicaid, would result in little emphasis on EMS, which is the central thesis of our problem. The Department of Homeland Security, on the other hand, with its focus on domestic preparedness and public safety, is a natural fit and will convey higher prominence for EMS. This is also consistent with HHS' view; in their April 2004 biodefense preparedness press release, they acknowledged, "The Department of Homeland Security creates a focal point for federal leadership."[10]

AEMS formed a coalition of EMS organizations in 2002 to raise awareness of EMS issues. They succeeded in having Senate Bill 611 and House Bill 1240 submitted to create FICEMS.[11] The concept of FICEMS, in the absence of other solutions, could certainly compliment efforts of existing EMS offices. However, it has distinct challenges to achieve a unified voice for EMS in the executive branch and with Congress. This is effectively illustrated as follows: AEMS states on their web site that "*Currently, FICEMS does not exist*

*and needs legislation put it into action*." [sic] [12] Interestingly, the U.S. Fire Administration's (USFA) web site states, "*FICEMS is currently chaired and administered by the U.S. Fire Administration.*"[13] The AEMS vision of FICEMS, juxtaposed with USFA's assertion of their oversight of it, well describes how an interagency committee can be manipulated, or worse, crippled by parochial interests of individual program offices. This substantiates and strengthens the GWU report's recommendation for "*the establishment of the U.S. Emergency Medical Services Administration (USEMSA) that should be modeled after, and be at an equivalent level to, the U.S. Fire Administration (USFA)*." [14]

AEMS, in opposing the conclusions of the GWU report,[15] also suggests that we wait for the Institute of Medicine's report *The Future of Emergency Care in the United States Health System.* [16] We agree that the IOM report will be a valuable and important analysis of the wide spectrum of emergency health care; however, it will likely amplify issues already identified. In the context of optimizing EMS representation in the federal government and gaining financial parity with our fellow first responders, we must not delay the solution.

As the federal government focused its attention upon improving the protection and capabilities of first responders, it is self-evident that law enforcement (through the Department of Justice) and fire services (through the U.S. Fire Administration) were most cohesively represented in Congress. EMS, with disparate program offices in various federal agencies, could not similarly speak with a unified voice; therefore, EMS received virtually no funding. This created a dangerous gap. A critical element of our first responders, those responsible for providing life-saving health care, has been left undertrained and unprotected.

## Conclusion

The International Association of Flight Paramedics believes the optimal solution to advance EMS in the federal government, both from a policy and financial perspective, is to create a U.S. EMS Administration in the Department of Homeland Security. Further, we support the objectives posited by the GWU Homeland Security Policy Institute report, including the creation of a national EMS training academy, data collection and research. This new agency should incorporate key national EMS projects in varying stages of development and implementation: the National EMS Agenda for the Future, Rural EMS Agenda for the Future, National EMS Scope of Practice, and National EMS Information System. The IAFP strongly asserts that the USEMSA must not be assumed under USFA. Such a move may irrevocably subjugate EMS to the fire service in the eyes of providers, government and the public. EMS must have autonomy to effectively advance as a public safety and health care entity.

The IAFP applauds the efforts of AEMS. We disagree with their conclusion that FICEMS is the solution. While FICEMS offers an opportunity for numerous EMS-related offices to communicate, it offers no consolidation of mission. EMS needs a "center of excellence" on equal footing with law enforcement and fire services. This is best provided by a centralized and readily-identifiable U.S. EMS Administration. It belongs in DHS, where Congress has philosophically aligned public safety and domestic preparedness, and has directed adequate appropriations.

The EMS Administration, with its prominent role in DHS, can comprehensively oversee EMS issues in consultation with HHS and other related federal departments. They could more effectively secure and administer grants that are accessible to all providers of emergency medical services. In particular, hospitals and other entities that provide EMS need full

consideration for funding, education, and planning lest a large portion of our first response capability will remain unaddressed and unprepared. The U.S. EMS Administration can assure that EMS will share a seat at the table as a core component of health care, public safety, and domestic preparedness.

The International Association of Flight Paramedics, whose members are deeply rooted in EMS, looks forward to actively participating with the federal government to strengthen EMS in the 21st century. We also encourage our fellow associations, particularly our colleagues in the air and ground critical care community, to join us in supporting this initiative.

## Endnotes

1 National Research Council. 1966. Accidental Death and Disability: The Neglected Disease of Modern Society . Washington: National Academy of Sciences.

2 Department of Homeland Security. "Support for EMS Provided by the DHS Office of State and Local Government Coordination and Preparedness." A Report to the Committees on Appropriations of the United States Senate and House of Representatives. Washington, D.C.; May 2004: 42.

3 Department of Health and Human Services, "HHS Fact Sheet: Biodefense Preparedness: Record of Accomplishment" http://www.hhs.gov/news/press/2004pres/20040428.html

4 Advocates For EMS, About Us, http://www.advocatesforems.org/default.cfm/PID=1.37

5 "Emergency Medical Services: The Forgotten First Responder" Center for Catastrophe Preparedness and Response, New York University, March 2005: http://www.nyu.edu/ccpr/pdf/NYUEMSreport.pdf

6 "Back to the Future: An Agenda for Federal Leadership of Emergency Medical Services" Homeland Security Policy Institute, George Washington University, May 2005: http://homelandsecurity.gwu.edu/reports/HSPI_EMS_task_force_report_5-2-05.pdf

7 Journal of Emergency Medical Services, Platinum Resource Guide, Key EMS Statistics http://www.jems.com/jems/2004resources/guide1.html

8 Centers for Medicare and Medicaid Services, "Medicare Establishes New Ambulance Fee Schedule" , February 22,2002 http://www.cms.hhs.gov/media/press/release.asp?Counter=419

9 Senate Committee on Governmental Affairs. Hearing on Oversight of the Centers for Medicare and Medicaid: Medicare Payment Policies for Ambulance Services. November 15, 2001. Written Testimony of Mark D. Meijer, American Ambulance Association http://www.senate.gov/~gov_affairs/111501meijertestimony.htm

10 Department of Health and Human Services, "HHS Fact Sheet: Biodefense Preparedness: Record of Accomplishment" http://www.hhs.gov/news/press/2004pres/20040428.html

11 Advocates For EMS, Learn Our Issues, FICEMS Bill: http://www.advocatesforems.org/default.cfm/PID=1.9.24

12 ibid.

13 U.S. Fire Administration, Subject Directory, EMS/Rescue, FICEMS: http://www.usfa.fema.gov/subjects/ems/ficems.shtm

14 "Back to the Future: An Agenda for Federal Leadership of Emergency Medical Services" Homeland Security Policy Institute, George Washington University, May 2005, page 14: http://homelandsecurity.gwu.edu/reports/HSPI_EMS_task_force_report_5-2-05.pdf

15 Advocates for EMS, Press Releases, "Advocates for EMS responds to a George Washington University report on EMS funding" http://www.advocatesforems.org/Library/upload/GW_Report_Response.pdf

16 Institute of Medicine, The Future of Emergency Care in the United States Health System: http://www.iom.edu/project.asp?id=16107