



Consolidated Federal Leadership for Emergency Medical Services

*An Essential Step to Improve National
Preparedness:
A perspective from EMS on the front line*



**International Association of
Emergency Medical Services Chiefs**
*Representing the leadership of
EMS services providing over
3.3 million EMS responses annually*

**Emergency Medical
Service Labor Alliance**
*A national alliance of 20,000
EMS professionals*

December 20, 2010

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The Honorable Richard A. Reed
Special Assistant to the President for Homeland Security
Senior Director for Resilience Policy
The White House
Washington, DC 20504

Mr. Reed:

We would like to express our appreciation for your presentation at the International Association of Emergency Medical Services Chiefs (IAEMSC) Annual Leadership Summit in Washington, D.C. this past October. The Summit attendees found your presentation engaging, and were grateful for the opportunity to interact beyond the scheduled presentation.

Establishing the National Preparedness Goal with policy priorities from an emergency medical services (EMS) perspective has been impeded by the lack of a consolidated federal leadership of EMS within the United States. In fact, there is a growing body of evidence indicating that the lack of centralized federal guidance for EMS has contributed to the fragmentation of EMS systems across the country.

Pursuant to your recommendation, we are submitting the attached “white paper” for review and consideration. Included is a potential solution that could be implemented under the existing provisions of the Homeland Security Act of 2002.

This paper is the collaborative effort of the leadership of two national EMS organizations: The International Association of EMS Chiefs and The National EMS Labor Alliance. Our organizations are united in our resolve to consolidate the federal leadership of EMS. We believe this action is essential to the delivery of our critical, pre-hospital health care service to Americans and to improve our nation’s preparedness.

The International Association of EMS Chiefs is a professional association established to support, promote and advance the leadership of EMS response entities and to advocate for the EMS profession. The IAEMSC membership consists of leaders from both career and volunteer EMS organizations from a diverse group of public and private EMS agencies that responded to over 3.3 million emergencies and transported over 2.78 million patients in 2008.

The National EMS Labor Alliance was established over twenty-five years ago as an information-sharing network of organized EMS providers across the country. The EMSLA now has over 20,000 members, as a coalition of EMS organized labor groups representing EMS professionals across the spectrum of EMS service delivery models and across the nation on national EMS issues.

Thank you for sharing your time with us. We hope the attached information will provide greater clarity and potential solutions to building national preparedness. We remain committed to participating in your efforts to ensure continued progress on building and sustaining emergency medical services, as a critical component of our nation's preparedness and resilience.

Please do not hesitate to contact us if you should have any questions.

Sincerely,



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Introduction

Emergency Medical Services (EMS) serves as a third branch of the public safety triad along with law enforcement and fire suppression partners, supporting the pre-hospital medical needs of millions of Americans each year. In its simplest form, EMS encompasses 911-call receipt and processing, pre-arrival instructions, ambulance response, field-based medical interventions and patient transport to hospitals. EMS, however, is neither simple nor easy to define. As a profession, its responsibilities cross the fields of public safety, public health, social services and public education. Its configuration varies greatly from one service to the next and during any medical emergency it can represent the difference between life and death. EMS is delivered by 670,000 certified¹ local, state, federal, tribal and military personnel, working within volunteer and professional private, municipal, tribal and federal services. Each EMS department has a distinct identity, influenced by varying local and state regulations, availability of trained personnel, funding, delivery models and medical oversight. On a local level, the EMS response and level of care that a patient would receive may be determined solely based on which side of a particular street they are standing. This disparity is mirrored at the federal level, where the profession is supported by multiple stakeholders, representing multiple interests, but without a single unified federal administration wholly dedicated to providing national leadership, advocacy and guidance for EMS.

Following the terrorist attacks of September 11, 2001, the nation adopted a standardized operational strategy to maximize command and control of response assets, including EMS.² The fundamental concept of the National Incident Management System (NIMS) is the unified command of an incident under a clearly defined incident commander and associated lines of authority. This system is used as an emergency response doctrine, although its components are essential tenets to *any* organizational structure. While EMS personnel are taught to use NIMS to dictate field operations, EMS as a profession lacks clearly defined lines of authority or an incident commander on a national level. Vision, strategy and optimal pre-hospital patient care are not possible without such oversight and leadership. Effective, efficient, fully integrated and equitable delivery of pre-hospital services to the nation necessitates strategic command and control of all elements of the EMS system.

The purpose of this white paper is to outline a clear path for consolidated federal leadership of EMS in America and to delineate actions for improving the effective, efficient and equitable delivery of EMS under all conditions and for all hazards. The basis for this federal leadership consolidation for EMS currently exists in policy. The Department of Homeland Security, specifically the Under Secretary of Emergency Preparedness and Response, has the authority to establish and oversee a federal EMS

¹ National Highway Transportation Administration, EMS Workforce for the 21st Century: A National Assessment, 2008 , Washington DC Page 9

² In accordance with NIMS requirements, all assets are resource typed; the FEMA 508-3 document, *Typed Resource Definitions: Emergency Medical Services Resources*, published in 2009, identifies EMS as a response asset.

administration³. Leveraging this authority will have a resounding positive effect on the over 16 million patients transported by EMS agencies each year⁴, as well as the many others who benefit from EMS services other than transport each year.

Emergency Medical Services Past and Present

EMS has evolved considerably over the last several decades, with the majority of the foundations of modern EMS systems taking root in the mid-1960's. Subsequent to the publication of the 1966 National Academy of Sciences (NAS) white paper, *Accidental Death and Disability: the Neglected Disease of Modern Society*, preventable injuries related to automobile collisions became a national priority. This NAS document was influential in the decision to place federal EMS oversight within the National Highway Traffic Safety Administration (NHTSA), an office of the Department of Transportation (DOT).

Throughout the latter half of the 1960s and into the 1970s, EMS enjoyed broad guidance and support from DOT and the Department of Health, Education and Welfare (HEW),⁵ through its Health Services and Mental Health Administration. Both provided funding for EMS capacity building. In 1973, the EMS Systems Act (42 U.S.C. 300d) was passed, authorizing HEW to direct grant funding to EMS systems, resulting in a general expansion of the profession at the local and regional level.

In 1981, the Omnibus Budget Reconciliation Act rolled EMS funding into Preventable Health and Health Service block grants, giving states discretion to determine funding priorities. Unfortunately, most states chose to prioritize programs other than EMS and since that time there has been a steady decline in the funding, training and equipping of the nation's EMS. Without directly overseeing EMS funding, both the DOT and HEW struggled to continue their support of EMS. By 1983, HHS had dissolved their Office of EMS and subsequently the DOT was left to carry the additional burden without any additional funding. This decline in federal support and focus has contributed to the inconsistent provision of EMS in America today. Neighboring states have differing staffing levels, scopes of practice, levels of training, and available equipment. Similar disparities exist between urban, suburban, rural and frontier EMS agencies within states. As a result, patient outcomes vary widely based purely on geographic and political factors.

³ Since enactment of HSA 2002, DHS has reorganized its administrative structure through exercise of the authority of the Secretary under Section 872 (a), limited by sub-section (b), of the Homeland Security Act of 2002. The "Directorate of EP&R" is now FEMA and the title "Undersecretary of EP&R" is synonymous with the FEMA Administrator. Section 872 (b) specifically limits abolition of any agency, entity, organizational unit, program, or function established or required to be maintained by this Act. The Act requires the entity and functions of a Directorate and Undersecretary of EP&R.

⁴ Committee on the Future of Emergency Care in the United States Health System, Board on Health Care Services, *Future of Emergency Care: Emergency Medical Services at the Crossroads*, ed. Institute of Medicine (Washington, DC: National Academies Press, 2007), 1, http://books.nap.edu/openbook.php?record_id=11629.

⁵ When the Department of Education was created in 1979, HEW became the Department of Health and Human Services.

In 2005, recognizing the lack of coordination among federal agencies, the Secretary of Transportation, along with the Secretary of Health and Human Services and the Secretary of Homeland Security, acting through the authority of the Under Secretary for Emergency Preparedness and Response, established the Federal Interagency Committee on Emergency Medical Services (FICEMS).⁶ While the creation of FICEMS was a step in the right direction in recognizing the broad responsibilities of EMS, governance by committee without clear authority or responsibility is not a permanent or viable long-term solution, especially with no fiscal appropriation commensurate with the intent of the statute to accomplish the mission. A federal EMS administration fully dedicated to the interests and future of EMS, working in partnership with FICEMS, would provide the necessary oversight, leadership and support for EMS at the federal level that is currently lacking.

EMS as a Fragmented System without Centralized Federal Guidance

In 2007, the Institute of Medicine (IOM) published *Future of Emergency Care: Emergency Medical Services at the Crossroads*, which states “government leadership in emergency care is fragmented and inconsistent” and advocates for a lead federal agency to support EMS and to complement the existing Federal Interagency Committee on EMS (FICEMS).⁷ The IOM report is by no means the only reference to the limitations of the existing organizational structure of EMS, nor is it the sole independent study to recommend the establishment of a single lead federal entity dedicated to providing national oversight of an integral component of this country’s public safety and health care systems.⁸

EMS has made great strides in the last five decades, evolving from basic first aid and transportation to a veritable mobile emergency room staffed by extensively trained clinicians. These field clinicians represent the beginning of a continuum of advanced healthcare and, as the IOM identified, ‘safety net of the safety net’⁹. The evolution of EMS, however, has been stifled by the absence of a central federal oversight administration. This void serves as the single greatest impediment to the stability of service and the advancement of the profession. Expanding upon the challenges

The Institute of Medicine has identified the following systemic EMS problems arising from a lack of federal leadership:

1. *Disparities in Response times*
2. *Uncertain Quality of care*
3. *Insufficient coordination*
4. *Lack of readiness for disasters*
5. *Divided professional identity*
6. *Limited evidence base*²

**See Appendix AB for full description*

⁶ Committee Reports 109th Congress (2005-2006); House Report 109-203. Sec. 10202. Emergency Medical Services. (a) (1).

⁷ Institute of Medicine of the National Academies. 2007. *Future of Emergency Care: Emergency Medical Services at the Crossroads*. Washington, D.C: The National Academies Press.

⁸ FICEMS was initially created based on recommendation to have better federal coordination. Additional reports, including The George Washington University Homeland Security Policy Institute Issue Brief, *Back to the Future: An Agenda for Federal Leadership of Emergency Medical Services*, further advocate for the need for federal leadership and identify FICEMS as an inadequate solution.

⁹ *ibid*

outlined by the Institute of Medicine, the absence of a central federal authority presents the following disparities, inequities and challenges:

Disparities in Health Outcomes

Limited local, state and federal subsidies or grant funding has resulted in a dependence on transport revenue to support system costs. With transports influencing revenue, there is a direct correlation between operational budget size and annual transports. EMS is an essential public safety and public health service, and as such, must have adequate capacity to surge to deal with mass casualty incidents and spikes in demand. It is unconscionable that low transport volumes and/or high rates of uninsured patients may equate to inadequate services. All Americans who call on EMS during their times of greatest need should have confidence that *regardless* of whether their local EMS provides 1,000 transports a year or 100,000, they will get the same level of care. As it stands, there is extensive variation in the availability and quality of EMS across the nation. Ambulance response times are predicated on workforce levels, which are heavily influenced by transport reimbursement. Limited staffing resulting from reimbursement-based EMS system design or from EMS workforce shortages result in increased times for ambulances to reach critical patients. Ron Freemont, NREMT-P, of the Omaha (NE) Tribal Rescue, supports a service zone of 2,591 square miles; the 6700 residents depend on emergency medical services that are handled with used ambulances rented from the federal government.

If you experienced cardiac arrest, would you rather be in downtown Seattle, Washington or Omaha, Nebraska?

If you chose Seattle, your likelihood of survival would be 15 times greater.¹⁰

In May of 2005, USA Today published a series of reports on Ventricular Fibrillation (VF) cardiac arrests and arrest patient survival rates among 50 US cities,¹¹ although only 40 responded to their request for data. The report included data (see Appendix C) demonstrating a dramatic range of survival rates, despite the commonly accepted definitive treatment for VF- defibrillation. Several cities reported survival rates in the 40% range. Given the same life threatening cardiac arrhythmia, nine other US cities reported single digit survival rates, the lowest being 3%. Fifteen cities did not track any outcome data relative to VF survival rates. Nine cities refused to provide data on survival rates, despite providing data on the number of VF occurrences. The average VF survival rate, based on reported rates, was 17%, or less than half of what was possible in certain cities. When accessing the data online, the first sentence one is presented with is, “The likelihood of surviving a sudden cardiac arrest triggered by a deadly short-circuit depends on where you are when it strikes.”¹² The report concluded that if equitable EMS care were to be delivered to all Americans, with respect to this specific cardiac emergency and with an average national survival rate of 20%, an additional 2,265 lives could be saved on an annual basis. This number of potential American lives saved rivals the success of efforts to protect the nation from high-level terrorist threats. And yet, this specific cardiac

¹⁰ USA Today, <http://www.usatoday.com/graphics/life/gra/ems/flash.htm>.

¹¹ USA Today, series of articles published in May of 2005, consolidated in online report in reference 5.

¹² USA Today, series of articles published in May of 2005, consolidated in online report in reference 5.

emergency represents only an estimated 1-2% of the hundreds of thousands of emergencies that the nation's EMS systems face on a daily basis.¹³ National level standards of care and equitable delivery of EMS will result in much higher survival rates across the entire spectrum of pre-hospital medical emergencies. In addition, improvements in patient outcomes and conditions through consistent, national evidence-based standards of care will directly relate to overall downstream national health care system cost savings through reduced lengths of in-patient stays and rehabilitation costs.

The USA Today report also presented evidence of a glaring lack of standard data reporting from EMS agencies. While response times represent but one criterion for EMS system performance, the report found that response time data were reported in several different formats, reporting was refused altogether, or the data were not collected. Standardized national EMS system reporting criteria are critical to equitable, efficient and effective EMS system performance management and improvement.

These issues represent perhaps the tip of the iceberg. Even with the limited outcomes data that are available, there are clear indications of health disparities across the EMS field. Investment in more extensive data collection, using standardized collection methods, would certainly highlight further disparities and inequities in standards of care in EMS service provision not only between urban and rural areas, but from one community to the next. EMS services must maximize the use of their limited funding, resulting in allocation of limited resources for training, equipment and personnel toward the types of patients and injuries or illnesses the service will most likely encounter. As a direct result of the fact that children comprise a relatively small percentage of EMS call volume, most EMS systems are ill prepared to serve the unique needs of pediatric patients during an emergency.¹⁴ If this exists as a day-to-day problem, then how can EMS possibly be prepared to meet its call for duty in a disaster situation? In the National Commission on Children and Disasters report to the President and Congress, the Commission drew from a 2006 IOM report to conclude, "On a daily basis a great disparity exists across the nation in the quality of adult and pediatric emergency care, which is exacerbated by disasters."¹⁵ The Commission's report recommended stronger EMS pediatric performance and accountability measures, and as a key recommendation, that The President and Congress "...clearly designate and appropriately resource a lead federal agency for emergency medical services (EMS) with primary responsibility for the coordination of grant programs, research, policy, and standards development and implementation."

¹³ This is the call volume for cardiac arrests within Boston, Massachusetts, provided by Boston EMS and Denver, Colorado, provided by Denver Health EMS the 9-1-1 emergency medical service providers for the respective cities. Without having this information for the country, it is assumed that it is consistent with Boston and Denver data.

¹⁴ Fisher, G. R., Ludwig, S. Textbook of Pediatric Emergency Medicine. Lippincott Williams & Wilkins, 2010. Page 97.

¹⁵ National Commission on Children and Disasters. *2010 Report to the President and Congress*. AHRQ Publication No. 10-M037. Rockville, MD: Agency for Healthcare Research and Quality. October 2010.

Variable Training and Certification Requirements

Simply put, an EMT is not an EMT and a Paramedic is not a Paramedic. The qualifications of personnel holding the same title vary greatly depending on the service they work for and the state they work in. As a step in the right direction, EMS education is becoming more standardized; the EMT and Paramedic textbooks are consistent across the country and a nationally recognized EMT certificate is available, although it is not recognized in all states. Standardizing training and certification requirements are necessary to ensure consistent and equitable care for patients, regardless of where they live. Regionalization of EMS services and the ability of personnel to apply their credentials across states, should they relocate or be needed to provide mutual aid in the case of a major incident requiring EMS professionals from other jurisdictions, require standardization of training and capability across localities, states and the nation. Each state has the authority to establish training, certification and continuing education requirements; individual departments can also augment these standards. Within Boston (MA) EMS, for example, all new EMT hires holding the Commonwealth of Massachusetts certification enter a six-month recruitment period comprised of three months of classroom and three months of field-based training prior to beginning their probationary period working in the field as an EMT. Many other EMS services have similar emphases on training beyond states' minimum standards, although funding limitations and data validating the return on investment for additional training inhibit other services from applying similar practices.

Equipment Limitations

As first responders and clinicians, EMT's and Paramedics rely on equipment for responding and transporting patients, coordinating with partner agencies, providing medical care, and protecting themselves. EMS-specific equipment is often manufactured as equipment intended for other professions or health care settings with slight, or often no variations from that used in inpatient or other environments; the lack of data regarding the appropriateness of which has hindered change. Further, with departments working independently and a lack of higher-level coordination and oversight, consolidated buying power is not leveraged to influence product development as it is in other industries. Comprehensive research, which no individual department or state could afford, on the appropriateness of equipment, from vehicles to essential pediatric equipment¹⁶ and stretchers, as it pertains to patient care and personnel safety, is lacking. While other public safety services receive extensive grant funding to procure necessary equipment, private-sector EMS agencies are restricted from accessing federal funding, and municipal departments receive a fraction compared to their public safety counterparts. In many parts of the country EMS personnel do not have interoperable radios or the personal protective equipment necessary to support daily and disaster operations, even though as we saw on September 11th, they will be expected to be among the first on scene.

¹⁶ *ibid*

Inadequate Personnel and Patient Safety Resources and Standards

Essential to the mission of Emergency Medical Services is the safety and the well being of both the patient and the responder. Although training, resources and funding affect safety, it is sufficiently important to warrant additional attention. Failures in EMS can cost lives or drive up health care costs due to increased patient disability and burden on hospitals and tertiary care facilities; the extent of which is unknown without necessary data collection and analysis. Among the responders to the September 11, 2001 attacks on the World Trade Center buildings, were New York City EMS personnel. In the nine years since then, EMS agencies across the country have struggled to be recognized as a priority within Homeland Security grant investments. While municipal EMS departments may benefit from Incident Command System training and interoperable radios, the absence of a national administration to advocate on behalf of the profession has resulted in EMS' consistently receiving only a fraction of the investment enjoyed by their public safety counterparts. In, 2005 the New York University issued a review of the Federal Homeland Security Grant programs and determined that only 5% of the available funding went to the EMS discipline¹⁷.

Insufficient Funding

In 1986 Congress passed the Emergency Medical Treatment and Active Labor Act (EMTALA), a component of the Consolidated Omnibus Budget Reconciliation Act, which requires medical providers, including EMS, to provide emergency health services to anyone who needs care. This requirement, coupled by a drastic downturn in federal support for EMS over the last few decades, and an assumption that EMS departments can fully capture costs through transport reimbursements presents challenges to effectively, efficiently and equitably delivering out of hospital life-saving services. Regions with low call volume, extensive service zones and higher proportions of uninsured patients are particularly vulnerable. While municipal EMS departments may receive some state or local subsidies, they are often not sufficient to allow for the ready reserve necessary to handle a disaster of even moderate proportions. With few exceptions, EMS agencies have been forced to make do with the funding they have, reducing staffing, buying less equipment or replacing it less frequently, providing less training or professional development opportunities, and ultimately providing a lower standard of patient care. There is neither true system cost recovery for optimal and timely service delivery, nor evaluations of the potential cost savings associated with EMS care. Through a national systemic approach, opportunities would certainly present for reducing health care costs and restructuring reimbursement practices. By encouraging and reimbursing prevention strategies, less costly and more effective patient disposition alternatives such as treat and release, expanded EMS mission treatments, and transports to alternate and more appropriate levels of care such as clinics and community health centers instead of emergency departments, when appropriate, there are surely benefits and cost-savings to be derived for the greater health care system.

¹⁷ 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>

Lack of Evidence-based Standards and Data

The need for national standards is evident in the recent requirements for departments to provide uniform data sets to the National EMS Information System (NEMSIS). The need to have useable data that allows for systems research, policy development and provider safety development cannot be understated. Currently the NEMSIS system is struggling to meet its mandate because the individual states have not incentive or fiscal support to provide the data to NEMSIS. Many EMS agencies nationally are not using electronic patient care reporting, limiting the ability to capture and provide the required information. This has the potential to create delays or gaps in data capture. How to use the data is another question in itself. Even if these data are successfully collected, not having a federal EMS administration will prevent the appropriate use of the data to guide clinical practices, service configuration, and training and education, as well as informing equipment and safety decisions. EMS-specific evidence-based benchmarks and standards are essential for the creation of national standards of care and credentialing to drive optimal patient care and regionalized response operations. Without these data, it is impossible to fully comprehend the state of Emergency Medical Services within the country.

Existing Authority for an EMS Administration within DHS

Through the Homeland Security Act of 2002, Public Law 107-296, the Department of Homeland Security has not only the authority, but also the responsibility to “ensure the effectiveness of emergency response providers to terrorist attacks, major disasters, and other emergencies” (Public Law 107-296, Title 5, section 502, sub-section1). Within section 2 (6) of the Act, “The term “emergency response providers” includes federal, state and local emergency public safety, law enforcement, emergency response, emergency medical (including hospital emergency facilities), and related personnel, agencies, and authorities.” DHS Management Directive 9100 organizes the roles and responsibility outlined herein, within the office of the DHS Under Secretary for Emergency Preparedness and Response.

EMS has unique and distinct responsibilities as an essential component of the nation’s response community, and is recognized as part of the nation’s critical infrastructure and key resources (CIKR) as one of five disciplines of the emergency services sector (ESS). The ESS is one of eleven CIKRs identified in HSPD-7 as being under the responsibility of the Department of Homeland Security and its component agencies¹⁸. Under the National Infrastructure Protection Plan, DHS, as the Sector-Specific Agency (SSA), is charged with the protection of EMS and the other emergency services sector disciplines—law enforcement, fire and emergency services, emergency management and public works. As the SSA over the emergency services sector, DHS is already responsible for the development and implementation of a Sector-Specific Plan to define goals and objectives and sector-level performance feedback.

The Department of Homeland Security currently supports the response capabilities of numerous response entities that are components of the Department. These entities have day-to-day response operational functions as well as in disasters. The architecture exists for DHS to support EMS as the lead federal agency. Under Secretary of Emergency Preparedness and Response’s responsibilities are consistent with what have been identified as gaps in federal leadership for EMS in numerous analyses. In addition, DHS has been building the capacity for medical response support through the establishment of the DHS Office of Health Affairs (OHA) in its reorganization in 2007. Currently, the Office of Medical Readiness under the OHA has many of the federal support responsibilities that EMS is currently lacking within its purview. Researching EMS safety and equipment also falls within the existing architecture of DHS under its Science and Technology Directorate.

Subsequent federal legislation, most notably the Safe, Accountable, Flexible, and Efficient Transportation Equity Act: A Legacy for Users (SAFETEA-LU), section 10202 “Emergency Medical Services”, extends the authority of the Under Secretary for Emergency Preparedness and Response to be an essential element to the creation of FICEMS in addition to an ongoing ‘significant role’.¹⁹ Establishment of a federal EMS

¹⁸ United States. *National Infrastructure Protection Plan Partnering to Enhance Protection and Resiliency*. [Washington, D.C.]: U.S. Dept. of Homeland Security, 2009.
<<http://purl.access.gpo.gov/GPO/LPS113950>>

¹⁹ *ibid*

administration is not only allowable under the Homeland Security Act of 2002; it is a natural complement to the Under Secretary's existing role with FICEMS.

Recommendation:

Establishment of a Federal EMS Administration within the existing DHS Directorate of Emergency Preparedness and Response.

National EMS Systems Improvement

- Establish evidence-based national standards for EMS system performance measurement.
- Establish a National EMS Academy to promulgate and implement national education standards and certification necessary for functional regionalized EMS systems.
- Utilize enhanced national EMS data collection system to implement EMS system improvement, and to drive optimal patient care and performance measurement.
- Establish EMS leadership competencies consistent with identified national core and expanded health care missions.
- Maintain public accountability and transparency for all aspects of EMS systems nationally.
- Institute training and workforce development programs consistent with national EMS system improvements.
- Regionalization of EMS to optimize resources and service delivery.
- Maintaining critical workforce levels.
- Advocacy and advancements in personnel and patient safety.

National Role within Existing Core Mission of EMS

- Enhance national capability to deliver timely, effective, and equitable pre-hospital emergency medical care to all individuals.
- Ensure nationally, EMS' ability to mitigate, prepare for, and respond to all major incidents and hazards without degrading other core mission responsibilities.
- Integrate EMS into the National Response Framework as a distinct entity, under clear lines of responsibility and authority.
- Enhance the capability of the EMS system in conducting research on and maintenance of the critical national EMS workforce, and its response and readiness capabilities.
- Implement and maintain evidence-based medical oversight of all aspect of national core missions.
- Through the use of grant funding, identify and implement national EMS safety standards, as well as the procurement of and training on the use of safety equipment for EMS delivery in all hazards.

Expanded Health Care Mission

- Plan and implement delivery of expanded role health care services consistent with the Health Care Reform Act.
- Implement and maintain evidence-based medical oversight of national EMS expanded roles.
- Plan for and deliver mitigating health care services to the public in a declared Public Health emergency.

- Research, plan, and implement regionalized EMS systems to optimize available EMS resources.
- Research new interventions and technologies to support expanded health care mission.

EMS Funding

- Identify evidence-based health care system cost savings realized through timely, effective, and equitably distributed EMS health care.
- Identify potential cost savings to health care system from expanded EMS mission interventions.
- Determine the actual cost of timely, effective, and equitably distributed EMS health care.
- Re-align federal reimbursements for EMS based on realized savings and actual costs for the delivery of timely, effective, and equitable EMS care.
- Establish incentive research grants to EMS systems in order to improve patient outcomes and reduce health care costs.
- Establish EMS grant funding to maintain critical national EMS workforce levels and incident response capabilities.
- Establish grant funding programs for equipment and training to improve EMS workforce and patient safety.

Summary

One of the fundamental keys to the practice of Emergency Medical Services is the early evaluation of vital signs, diagnostic indications of a patient's condition, followed by the timely initiation of appropriate treatment to preserve and improve the quality of life for our patients. The value of experience of an EMS provider is not measured in his or her ability to understand the basic fundamentals of the concept of obtaining this information, but rather the ability to interpret it, to differentiate between subtle variations in these signs and to respond appropriately.

By all accounts, from numerous studies of EMS throughout the recent years, EMS nationally is suffering from significant issues as demonstrated by its abnormal vital signs. These EMS vital signs are no longer subtly abnormal and the time for proactive measures may have already passed.

A lead federal EMS administration has been repeatedly identified as a fundamental corrective step in all of these national studies and the need for action was determined to be critical. Recent years and economic conditions have only increased the criticality of the need for federal action regarding the nation's EMS.

Despite differing service levels, treatment protocols, and local and state regulation, EMS has maintained an admirable degree of cohesion and unity of mission. EMS delivers life-saving and beneficial treatment and transport to tens of millions of Americans on a 24-hour per day, 365 days per year basis under all conditions and in all hazards.

Within the Homeland Security Act of 2002 (Public Law 107-296), the Department of Homeland Security has not only the authority, but the responsibility to "ensure the effectiveness of emergency response providers to terrorist attacks, major disasters, and other emergencies" through the Under Secretary of Emergency Preparedness and Response. This requirement is memorialized in clear and unambiguous language.

In this nation, and this day and age, it goes without arguing that every response to these emergencies must also be safely, equitably and efficiently delivered.

In addition to the clear policy responsibility and authority to oversee EMS, the Department of Homeland Security, through the Under Secretary of Emergency Preparedness and Response, currently has the infrastructure and expertise needed to ensure the safe, effective, efficient and equitable delivery of EMS to the nation by providing leadership, guidance, and support.

Local EMS departments, agencies, regions and states, have taken EMS as far as they can; the federal government must leverage existing authorities and infrastructure to establish a national EMS administration within DHS. Doing so will save lives and improve the safety and security of Americans and the men and women in EMS who serve them.

Appendix A – Title V, Sec. 501

PUBLIC LAW 107–296—NOV. 25, 2002 116 STAT. 2213

TITLE V—EMERGENCY PREPAREDNESS AND RESPONSE

SEC. 501. UNDER SECRETARY FOR EMERGENCY PREPAREDNESS AND RESPONSE.

There shall be in the Department a Directorate of Emergency Preparedness and Response headed by an Under Secretary for Emergency Preparedness and Response.

SEC. 502. RESPONSIBILITIES.

The Secretary, acting through the Under Secretary for Emergency Preparedness and Response, shall include—

- (1) helping to ensure the effectiveness of emergency response providers to terrorist attacks, major disasters, and other emergencies;
- (2) with respect to the Nuclear Incident Response Team (regardless of whether it is operating as an organizational unit of the Department pursuant to this title)—
 - (A) establishing standards and certifying when those standards have been met;
 - (B) conducting joint and other exercises and training and evaluating performance; and
 - (C) providing funds to the Department of Energy and the Environmental Protection Agency, as appropriate, for homeland security planning, exercises and training, and equipment;
- (3) providing the Federal Government’s response to terrorist attacks and major disasters, including—
 - (A) managing such response;
 - (B) directing the Domestic Emergency Support Team, the Strategic National Stockpile, the National Disaster Medical System, and (when operating as an organizational unit of the Department pursuant to this title) the Nuclear Incident Response Team;
 - (C) overseeing the Metropolitan Medical Response System; and
 - (D) coordinating other Federal response resources in the event of a terrorist attack or major disaster;
- (4) aiding the recovery from terrorist attacks and major disasters;
- (5) building a comprehensive national incident management system with Federal, State, and local government personnel, agencies, and authorities, to respond to such attacks and disasters;
- (6) consolidating existing Federal Government emergency response plans into a single, coordinated national response plan; and
- (7) developing comprehensive programs for developing interoperative communications technology, and helping to ensure that emergency response providers acquire such technology.

Appendix B – IOM Information on Systemic Problems

Passage taken directly from: Institute of Medicine of the National Academies. 2007. *Future of Emergency Care: Emergency Medical Services at the Crossroads*. Washington, D.C: The National Academies Press. Pages 3-4.

Systemic Problems

Despite the advances made in EMS, sizable challenges remain. At the federal policy level, government leadership in emergency care is fragmented and inconsistent. As it is currently organized, responsibility for pre-hospital and hospital-based emergency and trauma care is scattered across multiple agencies and departments. Similar divisions are evident at the state and local levels. In addition, the current delivery system suffers in a number of key areas:

- **Insufficient coordination**—EMS care is highly fragmented, and often there is poor coordination among providers. Multiple EMS agencies—some volunteer, some paid, some fire-based, others hospital or privately operated—frequently serve within a single population center and do not act cohesively. Agencies in adjacent jurisdictions often are unable to communicate with each other. In many cases, EMS and other public safety agencies cannot talk to one another because they operate with incompatible communications equipment or on different frequencies. Coordination of transport within regions is limited, with the result that the management of the regional flow of patients is poor, and patients may not be transported to facilities that are optimal and ready to receive them. Communications and handoffs between EMS and hospital personnel are frequently ineffective and omit important clinical information.
- **Disparities in response times**—The speed with which ambulances respond to emergency calls is highly variable. In some cases this variability has to do with geography. In dense population centers, for example, the distances ambulances must travel are small, but traffic and other problems can cause delays, while rural areas involve longer travel times and sometimes difficult terrain. Determining the most effective geographic deployment of limited resources is an intrinsic problem in EMS. But speed of response is also affected by the organization and management of EMS systems, the communications and coordination between 9-1-1 dispatch and EMS responders, and the priority placed on response time given the resources available.
- **Uncertain quality of care**—Very little is known about the quality of care delivered by EMS. The reason for this lack of knowledge is that there are no nationally agreed-upon measures of EMS quality and virtually no accountability for the performance of EMS systems. While most Americans assume that their communities are served by competent EMS systems, the public has no idea whether this is true, and no way to know.

- **Lack of readiness for disasters**—Although EMS personnel are among the first to respond in the event of a disaster, they are the least prepared component of community response teams. Most EMS personnel have received little or no disaster response training for terrorist attacks, natural disasters, or other public health emergencies. Despite the massive amounts of federal funding devoted to homeland security, only a tiny proportion of those funds has been directed to medical response. Furthermore, EMS representation in disaster planning at the federal level has been highly limited.

- **Divided professional identity**—EMS is a unique profession, one that straddles both medical care and public safety. Among public safety agencies, however, EMS is often regarded as a secondary service, with police and fire taking more prominent roles; within medicine, EMS personnel often lack the respect accorded other professionals, such as physicians and nurses. Despite significant investments in education and training, salaries for EMS personnel are often well below those for comparable positions, such as police officers, firefighters, and nurses. In addition, there is a cultural divide among EMS, public safety, and medical care workers that contributes to the fragmentation of these services.

- **Limited evidence base**— The evidence base for many practices routinely used in EMS is limited. Strategies for EMS have often been adapted from settings that differ substantially from the pre-hospital environment; consequently, their value in the field is questionable, and some may even be harmful. For example, field intubation of children, still widely practiced, has been found to do more harm than good in many situations. While some recent research has added to the EMS evidence base, a host of critical clinical questions remain unanswered because of limited federal research support, as well as inherent difficulties associated with pre-hospital research due to

Appendix C – USA Today 2005 Cardiac Arrest Report

City	# of VF victims	Survival Rate	First Responder Arrival	ALS Arrival
Albuquerque	90	Refused	4-5 min. avg	8 min. 90%
Atlanta	83	Refused	Refused	Refused
Austin	131	21%	5.76 min. avg	7:13 avg
Baltimore	130	Unknown	3:56 avg	7:18 avg
Boston	118	40%	10.2 min. 90%	7.3 min. avg
Charlotte NC	108	Refused	4:35 avg.	11:00 91%
Chicago	391	Refused	Refused	Refused
Colorado Springs	72	6%	4.86 min. avg	7:02 avg
Columbus	142	22%	5:25 avg	5:25 avg
Dallas	228	18%	4:40 avg	5:27 avg
Denver	111	Unknown	4:00 avg	5:50 avg
Detroit	190	Refused	Refused	Refused
El Paso	113	11%	Unknown	10:00 avg
Fresno	86	Unknown	4.5 min. avg	7:37 avg
Ft Worth	107	Refused	Refused	Refused
Honolulu	74	Refused	Refused	Refused
Houston	391	21%	5.5 min. avg.	5.8 min avg
Indianapolis	156	7%	3:50 avg	4:30 avg
Jacksonville	147	Unknown	6:00min 72%	10:00 avg
Kansas City, MO	88	20%	5:00 min 78%	9 min. 91%
Las Vegas	96	12%	Refused	Refused
Long Beach	92	Unknown	6:00min 88%	10:00 avg
Memphis	130	Refused	Refused	Refused
Miami	72	11%	4:45 avg	4:45 avg
Milwaukee	119	27%	6:00 min 90%	10 min. 91%
Nashville	108	5%	7:00 min. avg.	9:23 avg
New Orleans	97	Refused	Refused	Refused
Oakland	80	6%	Unknown	Unknown
Oklahoma City	101	27%	Unknown	Unknown
Omaha	78	3%	Unknown	Unknown
Philadelphia	304	4%	7:37 90%	10:55 90%
Portland	106	49%	6:30 90%	6:30 90%
San Antonio	229	9%	Unknown	5:15 avg
San Francisco	155	22%	7.5 min 90%	8:17 avg
San Jose	179	6%	Unknown	Unknown
Seattle	113	45%	6:00min 87%	9:00 min. 78%
Tucson	97	12%	6:00min 82%	10:00 min. 93%
Tulsa	79	26%	Refused	Refused
Washington DC	114	4%	7:18 avg	7:18 avg
Total	5305	Avg 17%		

Appendix D – FICEMS

SAFE, ACCOUNTABLE, FLEXIBLE, EFFICIENT TRANSPORTATION EQUITY ACT: A LEGACY FOR USERS

Subtitle B--Other Miscellaneous Provisions

SEC. 10202. EMERGENCY MEDICAL SERVICES.

(a) Federal Interagency Committee on Emergency Medical Services-

(1) ESTABLISHMENT- The Secretary of Transportation, the Secretary of Health and Human Services, and the Secretary of Homeland Security, acting through the Under Secretary for Emergency Preparedness and Response, shall establish a Federal Interagency Committee on Emergency Medical Services.

(2) MEMBERSHIP- The Interagency Committee shall consist of the following officials, or their designees:

(A) The Administrator, National Highway Traffic Safety Administration.

(B) The Director, Preparedness Division, Directorate of Emergency Preparedness and Response of the Department of Homeland Security.

(C) The Administrator, Health Resources and Services Administration, Department of Health and Human Services.

(D) The Director, Centers for Disease Control and Prevention, Department of Health and Human Services.

(E) The Administrator, United States Fire Administration, Directorate of Emergency Preparedness and Response of the Department of Homeland Security.

(F) The Administrator, Centers for Medicare & Medicaid Services, Department of Health and Human Services.

(G) The Under Secretary of Defense for Personnel and Readiness.

(H) The Director, Indian Health Service, Department of Health and Human Services.

(I) The Chief, Wireless Telecommunications Bureau, Federal Communications Commission.

(J) A representative of any other Federal agency appointed by the Secretary of Transportation or the Secretary of Homeland Security through the Under Secretary for Emergency Preparedness and Response, in consultation with the Secretary of Health and Human Services, as having a significant role in relation to the purposes of the Interagency Committee.

(K) A State emergency medical services director appointed by the Secretary.

(3) PURPOSES- The purposes of the Interagency Committee are as follows:

(A) To ensure coordination among the Federal agencies involved with State, local, tribal, or regional emergency medical services and 9-1-1 systems.

(B) To identify State, local, tribal, or regional emergency medical services and 9-1-1 needs.

(C) To recommend new or expanded programs, including grant programs, for improving State, local, tribal, or regional emergency medical services and implementing improved emergency medical services communications technologies, including wireless 9-1-1.

(D) To identify ways to streamline the process through which Federal agencies support State, local, tribal or regional emergency medical services.

(E) To assist State, local, tribal or regional emergency medical services in setting priorities based on identified needs.

(F) To advise, consult, and make recommendations on matters relating to the implementation of the coordinated State emergency medical services programs.

(4) ADMINISTRATION- The Administrator of the National Highway Traffic Safety Administration, in cooperation with the Administrator of the Health Resources and Services Administration of the Department of Health and Human Services and the Director of the Preparedness Division, Directorate of Emergency Preparedness and Response of the Department of Homeland Security, shall provide administrative support to the Interagency Committee, including scheduling meetings, setting agendas, keeping minutes and records, and producing reports.

(5) LEADERSHIP- The members of the Interagency Committee shall select a chairperson of the Committee each year.

(6) MEETINGS- The Interagency Committee shall meet as frequently as is determined necessary by the chairperson of the Committee.

(7) ANNUAL REPORTS- The Interagency Committee shall prepare an annual report to Congress regarding the Committee's activities, actions, and recommendations.