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International Association of Fire Chiefs
EMS Section

An Assessment of the
Institute of Medicine Recommendations
Emergency Medical Services at the Crossroads

Prepared for the IAFC Board of Directors, EMS Section members, and policy makers
Prepared by the EMS Section - January 2007

Introduction

Established in 1873, the International Association of Fire Chiefs (IAFC) is a powerful network of more than 12,000 chief fire and emergency officers. Our members are the world's leading experts in fire fighting, emergency medical services, terrorism response, hazardous materials spills, natural disasters, search & rescue, and public safety legislation. The IAFC's mission is to provide leadership to career and volunteer chiefs, chief fire officers and managers of emergency service organizations throughout the international community through vision, information, education, services and representation to enhance their professionalism and capabilities.

The IAFC Emergency Medical Services Section is one of the largest sections within IAFC with over 1,000 members. The Section promotes fire-based EMS by providing a forum for addressing fire service EMS issues, providing guidance and direction to the IAFC board and membership on fire service EMS issues, and representing fire-based EMS issues before the federal government and other EMS interest groups.

The IAFC EMS Section has undertaken a review of the Institute of Medicine (IOM) report dealing specifically with prehospital emergency care. The IOM set out to: examine the emergency care system in the United States; explore its strengths, limitations, and future challenges; describe a desired vision of the emergency care system; and recommend strategies required to achieve that vision. Their efforts build on past contributions, including the landmark National Research Council report, *Accidental Death and Disability: The Neglected Disease of Modern Society* in 1966, *Injury in America* in 1985, and *Emergency Medical Services for Children* in 1993.

The IOM goal was to examine the full scope of emergency care, from 9-1-1 and medical dispatch, to hospital-based emergency and trauma care. The three reports in the series, *Hospital-Based Emergency Care: At the Breaking Point, Emergency Medical Services At the Crossroads*, and *Emergency Care for Children: Growing Pains*, provide three different perspectives on the emergency care system. The series as a whole unites the often-fragmented prehospital and hospital-based systems under a common vision for the future of emergency care.

This effort is designed not to supplant the work of the IOM, but rather provide IAFC leadership, members, and other policy makers with our assessment of the IOM recommendations. Quite clearly, the IOM reports have garnered significant attention in the medical community. Its findings and recommendations provide an opportunity for the EMS community to make significant advances. In our assessment, some recommendations are ripe for immediate implementation and some require more discourse within the EMS community. In that fire-based EMS systems are some of the largest providers of prehospital medical care, the IAFC EMS Section is both knowledgeable and willing to actively engage in that discussion. As a starting point, we offer the following assessment of the IOM report on EMS.

IOM Recommendations

1. *The committee recommends that the Department of Health and Human Services and National Highway Traffic Safety Administration, in partnership with professional organizations, should convene a panel of individuals with multidisciplinary expertise to develop an evidence-based categorization system for EMS, EDs, and trauma centers based on adult and pediatric service capabilities.*

The IAFC EMS Section agrees in principal with this recommendation. The use of specific categorizations for trauma centers has assisted the proper routing of critical patients to appropriate facilities. While the criteria used must consider not just medical evidence, but also operational considerations, the recommendation has the potential to strengthen the structure of EMS delivery.

2. *The committee recommends that the National Highway Traffic Safety Administration, in partnership with professional organizations, should convene a panel of individuals with multidisciplinary expertise to develop evidence-based, model prehospital care protocols for the treatment, triage, and transport of patients.*

The IAFC EMS Section agrees in principal with this recommendation. The use of quality, evidence-based medical treatment protocols arguably will improve patient outcomes. However, it is important to consider the implications for local prehospital medical directors. Model protocols must recognize the legal imperatives of local medical direction; the need to modify model protocols based on emerging science and the requirement to allow innovations derived from effective quality assurance programs to emerge.

3. *The committee recommends that the Department of Health and Human Services convene a panel of individuals with emergency and trauma care expertise to develop evidence-based indicators of emergency care system performance.*

The IAFC EMS Section fully agrees with this recommendation. Along with numerous other voices in the EMS community, the IAFC EMS Section believes our communities can best be served by having effective EMS programs – something that can only be determined through the use of meaningful performance measures.

4. *The committee therefore recommends that Congress establish a demonstration program, administered by the Health Resources and Services Administration, to*

promote regionalized, coordinated, and accountable emergency care systems throughout the country, and appropriate $88 million over 5 years to this program.

The value of demonstration programs can often be significant. However, the IAFC EMS Section believes this recommendation will be required to be a successor to other recommendations made in the IOM report. For example, to be accountable, there must first be clearly defined performance measures. The IOM report calls for such work, yet their development of that and other components are needed before demonstration projects should be funded or begun. The IAFC EMS Section looks forward to assisting in the precursor activities and our participation in the design of such demonstration projects.

5. *Congress establish a lead agency for emergency and trauma care within 2 years of the publication of this report. This lead agency should be housed in the Department of Health and Human Services, and should have primary programmatic responsibility for the full continuum of EMS, emergency and trauma care for adults and children, including medical 9-1-1 and emergency medical dispatch, prehospital EMS (both ground and air), hospital-based emergency and trauma care, and medical-related disaster preparedness. Congress should establish a working group to make recommendations regarding the structure, funding, and responsibilities of the new agency, and develop and monitor the transition. The working group should have representation from federal and state agencies and professional disciplines involved in emergency and trauma care.*

The IOM report clearly notes the tension that has often existed in EMS system design and operations – most notably that between the domains of public safety and health care. We can not help but note the recent efforts to strengthen existing federal EMS leadership by elevating EMS within the Department of Transportation to 'Office' status. Elsewhere, we have heard calls for EMS leadership to be placed within the Department of Homeland Security. The IOM recommendation relocates EMS's home to Health & Human Services (HHS).

The IAFC EMS Section clearly desires EMS to have a visible and strong home in the federal government. However just as clearly, where that home should be located is still subject to significant debate among elected officials, various federal agencies and EMS stakeholders. We believe Congressional leaders should tackle this issue head-on by engaging all EMS participants in the policy process while maintaining a focus on raising the visibility of EMS in the federal government.

6. *The Department of Health & Human Services should adopt rule changes to the Emergency Medical Treatment and Active Labor Act (EMTALA) and the Health Insurance Portability and Accountability Act (HIPPA) so that original goals of the laws are preserved but integrated systems may further develop.*

The IAFC EMS Section agrees in principal with this recommendation. A constant obstacle to EMS research efforts has been the inability to link patient outcome to EMS service delivery. This recommendation will help overcome that impediment and permit EMS providers to see the results of their patient care.

7. *The committee recommends that the Centers for Medicare and Medicaid Services convene an ad hoc work group with expertise in emergency care, trauma, and EMS systems to evaluate the reimbursement of EMS and make recommendations regarding inclusion of readiness costs and permitting payment without transport.*

The IAFC EMS Section fully agrees with this recommendation – a fact well demonstrated by our active participation in the earlier effort of Negotiated Rule-Making that established the most recent reimbursement scheme. The IAFC EMS Section has recently requested that this process be initiated once again in light of proposed changes to the earlier work in which we so strongly participated.

8. *The committee recommends that state governments adopt a common scope of practice for EMS personnel, with state licensing reciprocity.*

The IAFC EMS Section agrees in principal with this recommendation. In fact, the IAFC EMS Section has participated previously in efforts by NHSTA to develop a common scope of practice. As a leading representative for a large portion of the prehospital community, we continue to be involved in such discussions. Further, we believe that state-licensing reciprocity, when properly implemented, can facilitate the recruitment of highly qualified EMS personnel.

9. *The committee recommends that states require national accreditation of paramedic education programs.*

The IAFC EMS Section recognizes the importance of quality paramedic education. As such, accreditation of paramedic programs is essential. Such a process, derived from a national accreditation program, could have significant benefit for EMS.

10. *The committee recommends that states accept national certification as a prerequisite for state licensure and local credentialing of EMS providers.*

The IAFC EMS Section encourages states to consider appropriate credentials from national certification organizations as an option for initial state licensure.

11. *Therefore, the committee recommends that the American Board of Emergency Medicine create a subspecialty certification in EMS.*

The IAFC EMS Section feels a subspecialty certification in EMS may have significant value. However, it is appropriate for this recommendation to be supported within the existing emergency medicine community in order to be successfully implemented.

12. *The committee recommends that states should assume regulatory oversight of the medical aspects of air medical services, including communications, dispatch, and transport protocols.*

The IAFC EMS Section agrees in principal with this recommendation. The FAA has acknowledged that it has not been their intention to regulate medical aspects of EMS care. In that states provide this medical regulation in all other EMS arenas, the recommendation to assure the same occurs in air medical programs is rational.

13. *The committee recommends that hospitals, trauma centers, EMS agencies, public safety departments, emergency management offices, and public health agencies develop integrated and interoperable communications and data systems.*

The IAFC EMS Section agrees in principal with this recommendation. The IAFC has been at the forefront of advocacy and implementation for interoperable communications. Recent success in this area by the IAFC and other public safety organizations resulted in congressional action to allocate additional spectrum for this purpose.

14. *Therefore, the committee recommends that the Department of Health and Human Services fully involve prehospital EMS leadership in discussions about the design, deployment, and financing of the National Health Information Infrastructure (NHII).*

The IAFC EMS Section agrees in principal with this recommendation. The present lack of focus in the NHII development regarding prehospital medical providers needs to be corrected. This can be accomplished by providing EMS leaders with the opportunity to assist in NHII design and implementation.

15. *The committee recommends that the Department of Health and Human Services, the Department of Transportation, the Department of Homeland Security, and the states elevate emergency and trauma care to a position of parity with other public safety entities in disaster planning and operations.*

The IAFC EMS Section recognizes the perceived, and in some locations actual, lack of parity that EMS is afforded in planning and operations. We believe this is a serious

oversight, as strong and robust EMS systems must be an integral component of the public safety fabric. However, we also believe the best manner in which this leadership role can be strengthened in by the integration of EMS into a fire-based model. Such a structure, already a major system design, has proven to be an effective and efficient method of EMS delivery in many of our nation's communities.

16. To address the serious deficits in health-related disaster preparedness, Congress should substantially increase funding for EMS-related disaster preparedness through dedicated funding streams.

The IAFC EMS Section agrees in principal with this recommendation. The potential for man-made and natural disasters to generate large demands on local EMS systems must be anticipated, planned for and funded. At present, too little emphasis has been paid to the implications of large-scale incidents impacting regional health resources. While an understanding of increased surge capacity is now being discussed, little substantive progress has been made. Such increased funding should not be at the expense of other first responder (i.e. FIRE Act, SAFER) grant funding and should emphasize regional approaches.

17. The committee recommends that the professional training, continuing education, and credentialing and certification programs of all the relevant EMS professional categories incorporate disaster preparedness training into their curricula and require the maintenance of competency in these skills.

The IAFC EMS Section fully agrees with this recommendation. The obvious changes and threats that exist today, and the role of EMS in protecting the nation's communities, requires medical professionals to be well prepared to manage large scale emergencies. The fire service has an advantage in this arena as our personnel are well versed in responding to and managing all hazards. This has resulted in fire-based EMS personnel already meeting the intent of this recommendation.

18. The committee recommends that federal agencies that fund emergency and trauma care research should target additional funding at prehospital EMS research, with an emphasis on systems and outcomes research.

The IAFC EMS Section agrees in principal with this recommendation. We further believe that efforts of federal agencies to define research questions related to prehospital system design and EMS outcomes requires input from all major advocacy groups including fire-based EMS providers.

19. *Congress should modify Federalwide Assurance Program (FWA) regulation to allow the acquisition of limited, linked, patient outcome data without existence of FWA.*

The IAFC EMS Section agrees in principal with this recommendation. The ability to access information that involves non-academic entities will permit more robust research to be performed. Such efforts will strengthen evidence based EMS protocols.

20. *The committee recommends that the Secretary of the Department of Health and Human Services conduct a study to examine the gaps and opportunities in emergency and trauma care research, and recommend a strategy for the optimal organization and funding of the research effort.*

The IAFC EMS Section agrees in principal with this recommendation. As noted earlier, good evidence-based research is lacking in many areas of EMS. Optimizing existing research efforts could well be an effective strategy.

Conclusion

The IAFC EMS Section believes the recent IOM reports provide a valuable opportunity. However changes in attitudes, legislative differences, organizational inertia, and funding all remain obstacles to fully recognizing the benefit the IOM recommendations could provide. Clearly, these challenges in public policy making can be navigated more easily when all major EMS stakeholders are involved. As the dialogue continues, the IAFC EMS Section will continue to be an active participant.

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