

UTAH DEPARTMENT OF HEALTH RESPONSE

To the Position Paper Regarding the proposal to move the Bureau of Emergency Medical Services from the Department of Health to the Department of Public Safety

10/25/2005

HISTORY AND BACKGROUND

Prior to 1966, most ambulance services were provided by mortuaries or a few police departments. When a patient was picked up, he was put in the back of the hearse unattended and taken to the hospital and had little if any care provided. If he survived that far, the patient was treated at the hospital, if not he was taken to the mortuary. Based on a White Paper, written by the National Institute of Sciences (the precursor of the Institute of Medicine), entitled “Accidental Death and Disability – The Neglected Disease of Modern Society”, the lack of medical care in the emergency realm was brought to light. This paper delineated how much death and disability could be averted if a system could be established to extend hospital emergency departments to provide emergent health care delivery to the streets and homes of ill and injured patients. Based upon the logic expressed in this paper, The Federal Emergency Medical Systems Act was passed by Congress in 1969 to establish minimum training and equipment standards for providing prehospital care.

In the late 60s, there was little, if any, interest by many fire departments to be actively involved in the provision of EMS. Other organizations stepped forward to provide this service. Many private companies were formed, some hospitals chose to provide ambulance services, and volunteer associations were formed in many rural areas. Many of these organizations are still actively providing service some 35 years later.

Shortly after the Federal law was enacted, the Los Angeles County Fire Department decided to implement an idea that originated in Dublin, Ireland, to place interns or highly trained technicians onboard ambulances to treat the most severely ill or injured patients. Thus the concept of paramedics was born and implemented. The television series “Emergency!” brought Johnny and Roy into America’s living rooms and the rest is history. Since that time, fire departments have essentially prevented themselves out of the business of fire fighting. With all of the emphasis on fire prevention, new building codes, sprinkler systems etc, the number of fire calls the fire service was dispatched to, continued to decline. The fire service has become progressively more active in the field of EMS. In most urban areas, the local fire service responses represent 10-15% fire calls and 85-90% EMS calls. Much of this service is provided as quick response or paramedic rescue (providing first response care to the patient but not transporting the patient). The third party payment system has established policy that only allows reimbursement for the transport of patients and they will only pay one prehospital provider. The fire service has found that unless they are transporting patients, it is very difficult to receive payment for their services.

The Utah Department of Health (DOH), Bureau of Emergency Medical Services was established (by statute in 1972, the Utah Ambulance Control Act) as a regulatory agency that establishes minimum baseline operational and certification standards for the

provision of emergency medical services. The Bureau is responsible for establishing minimum levels of competency for EMS providers and maintaining oversight of that competency.

Individuals are certified (EMT Basic, Intermediate or Paramedic) and are responsible for their certification or recertification. These certifications are based upon nationally approved curricula established by the National Highway Safety Administration (NHTSA).

Licensure is issued to agencies that will be providing ambulance (ground or air) or paramedic service. The Utah Legislature determined in 1972 (and has since revisited and reinforced that decision in 1981, 1999, 2003, and 2004) that EMS services could best be provided by licensing only one ambulance and/or paramedic service provider for each geographic service area. Therefore, a statewide system of EMS providers was established, by law, utilizing a public utilities monopoly model of licensing agencies in which the Utah Department of Health controlled access into the market, established maximum allowable rates, and exclusive geographic service areas. First responder agencies, dispatch centers, trauma centers and resource hospitals are designated.

This system was recently (2004) modified to allow municipalities and special service districts in Class One and Class Two counties to choose from approved applicants (qualified by the Department of Health) which agency they would like to provide service within their geographic service area. Levels of service (Basic EMT, Intermediate, or Paramedic) are offered to the local providers. It is their determination to choose which level of service they wish to provide to their community. Other operational issues regarding how services will be provided, configuration etc, are determined by the local agency. The protocols for granting licensure are explicitly delineated in either the Law or Administrative Rules. This is done specifically to eliminate any claims of favoritism or bias.

In 1981, there was a major recodification of Health Department laws. At that time, three separate laws (Ambulance Control Act, Mobile Paramedic Act, and the Advanced EMT Act) regarding EMS were rolled into one "EMS Systems Act". This was the first step in recognizing the integral role that EMS plays in the overall Healthcare system and that EMS was not just prehospital care but a continuum of care beginning with trained citizens accessing the system, through emergency medical dispatchers, the EMS field providers, emergency departments, critical care, and surgical facilities and rehabilitation facilities. The emergency medical SYSTEM works together to form a seamless safety net for the citizens of Utah. The EMS system truly is the intersection of public health, public safety, and medical care activities. The availability of quality EMS services is often the difference between life and death in a medical event or traumatic injury. EMS directly affects the public's health by providing immediate medical intervention for victims of traumatic events, heart attacks, strokes, and motor vehicle accidents. For EMS to accomplish its purpose, the system must provide for the efficient, effective, and coordinated delivery of health care services to handle emergencies. This requires working closely with not only the medical delivery system but other programs within the Department of Health such as CardioVascular disease control, Chronic Disease Control, Epidemiology, local Health Departments, and the Medical Examiners' Office.

CURRENT STATUS

As of September 27, 2005, of the 56 members of the National Association of State Emergency Medical Systems Directors, 40 are housed within their State Department of Health, five are housed in the Department of Public Safety and 11 are housed in an independent organization (such as an Office of EMS or EMS Board that reports directly to the Governor).

The Utah Bureau of EMS strongly suggests and facilitates the establishment of local EMS councils to incorporate all of the local players (such as dispatch, police, fire, hospitals, highway patrol, etc.) for the determination of local operational protocols. If these protocols delineate medical treatment, they are determined by the local group and must be signed off by the local off-line medical director for each agency. Local EMS operations are not in any way dictated by the State Department of Health just as Fire Department operations are not dictated by the State Department of Public Safety.

During any type of incident, the locals are in charge. In a disaster situation, all disasters are considered to be local. State agencies are only involved when requested by a local or county agency. The State role is that of support to the locals, not going in and taking over. Once again, the state agency does not dictate the locals' operational plans. State agency affiliation has no impact on local emergency operations.

Within Utah we have many different configurations for the delivery of EMS to communities. The configuration is determined at the local level. Many communities have separate first responders, ambulance services and Intermediate or Paramedic services which may or may not be affiliated with the local Fire Department.

The Bureau of EMS (BEMS) licenses or designates the following agencies:

| Classification of Agencies | Licenses or Designations |
|-----------------------------------|---------------------------------|
| Air | 11 |
| EMT – Basic | 15 |
| EMT – Intermediate | 67 |
| EMT – Intermediate Advanced | 1 |
| Paramedic | 34 |
| Quick Responders | 53 |
| Dispatch Centers | 36 |
| Resource Hospitals | 43 |
| Trauma Centers | 6 |

Of the agencies listed above, excluding the dispatch centers, trauma centers, and resource hospitals, the following chart delineates the agencies organizational affiliations:

Utah EMS Agency Organization

Urban = Wasatch Front counties, Rural = all other counties

Fire Based EMS = 59% Law Enforcement Based = 7% Other EMS Organizations = 34%

| Classification of Licenses and Designations | Rural | Rural Fire | Rural Police | Urban | Urban Fire | Urban Police | Total |
|---|-------|------------|--------------|-------|------------|--------------|-------|
| Air | 2 | 0 | 0 | 9 | 0 | 0 | 11 |
| EMT – Basic | 4 | 2 | 0 | 0 | 9 | 0 | 15 |
| EMT – Intermediate | 28 | 14 | 2 | 6 | 15 | 2 | 67 |
| EMT – Intermediate Advanced | 1 | 0 | 0 | 0 | 0 | 0 | 1 |
| Paramedic | 3 | 5 | 1 | 1 | 23 | 1 | 34 |
| Quick Responders Basic | 1 | 18 | 0 | 4 | 14 | 3 | 40 |
| Quick Responder Intermediate | 0 | 5 | 3 | 1 | 2 | 2 | 13 |
| Total | 39 | 44 | 6 | 21 | 63 | 8 | 181 |

SERVICE DELIVERY ISSUES

The Fire Service Issue Paper alludes to the fact that more and more responsibilities are being heaped upon our first responders. We agree entirely! Every year there is something new that has to be disseminated to the providers that require additional training or focus from licensed EMS providers. This is true of the police and fire disciplines as well. Each discipline is moving and growing so fast that coordination is truly necessary to avoid duplication and decide which changes will be adopted within a particular agency. These changes are particularly daunting to our rural, volunteer providers. In many rural areas, in order to keep the amount of training and special requirements from overwhelming their volunteers, a conscious decision has been made to keep fire, EMS, and police as separate entities with separate volunteer pools. The Bureau of EMS is currently working with the Department of Public Safety and Fire Marshal's Office to coordinate instructor education as well as having a venue to discuss curricula. Several years ago, the Bureau approached the State Fire and Rescue Academy with a proposal that allows Instructors certified by the Fire Academy to be recognized by the Bureau and therefore cut their EMS training requirements from three days to one day. This has been successfully enacted. The Fire Academy unfortunately was unwilling to reciprocate.

All EMS certification and recertification requirements are reviewed on a regular basis. Any new courses or mandatory training being required by the fire service are considered by their curricula and if it is determined that the curricula meets some of the EMS criteria, it is accepted for EMS Continuing Medical Education (CME) credits on an hour for hour basis. Approximately 15 years ago, the Bureau of EMS decided to allow local EMS agencies, such as Fire Departments, to do their own Basic EMT recertification practical examinations (as opposed to having to send their personnel to a centralized testing site). This necessitated having to train the individual department's training officers on the protocols and requirements for conducting these tests in a fair and equitable manner. Because EMS certification is issued to an "individual" who is personally responsible for their own certification, the Chiefs could determine that their employees are capable of managing their own certification requirements individually and choose not to offer recertification testing within their department. That would eliminate the need for the additional required training for their staff.

The Fire Service Report states: "By making this move all functions now handled by the fire service will be administered and coordinated in one office at the state level." That may work for those agencies that are fire service related, but the Bureau of EMS must take into consideration the entire picture of the state which includes many agencies with no fire service affiliation. This white paper does not address a mechanism for incorporating EMS services from anyone other than fire departments which would leave serious gaps in service and communication in our EMS statewide system.

This white paper makes a major assumption by stating that unified oversight would permit a more equitable distribution of funding. "This assumption" does not fit the reality of the current situation in our state. Currently, allocation of Federal Homeland Security funds is accomplished through eight, multi-county regions. Each region has representatives who participate in planning and orchestrating efforts within their own region across all emergency services. Each region is supposed to determine their own priorities and determine a plan for the distribution of the funds allotted to them. In addition, the distribution of these funds is overseen by a committee consisting of representatives from the Department of Public Safety, the State Fire Chief's Association, Bureau of EMS, State Sheriff's Association, the Emergency Managers Association and several others. The fire service/EMS is well represented.

As far as the EMS grants are concerned, the distribution of these funds is determined by State Law (26-8a).

UNITY OF COMMAND

Annex K of the State Emergency Operations Plan (EOP) states: "the affected local government(s) will control emergency medical, health and sanitation services. This also includes coordination of any medical and health services that may be made available by the American Red Cross and other voluntary organizations."

At the State Level, the State EOP clearly delineates "the Utah Department of Health will coordinate disaster-related medical services which shall include but are not limited to: ...Serves as the lead agency during planning for the coordination of public health, healthcare, and emergency medical activities during a disaster or state of emergency..."

This is further delineated in a Memorandum of Understanding (MOU) that has been in place since 1999 that clearly outlines the separation of responsibilities between the Department of Health and Emergency Management during normal operations. The Department of Health has designated the responsibilities of coordinating all disaster response activities to the Bureau of Emergency Medical Services, including all planning, exercise development, as well as implementation and coordination of incident management. Clearly, there is no role confusion between departments at the state level.

The White paper submitted by the Fire Chiefs cites as an example of lack of communication, the response to the August 1999 Tornado in Salt Lake City. We must take issue with their presentation of the facts in that incident.

At that point in time, Gold Cross Ambulance, Inc., was the exclusive ambulance provider for the City of Salt Lake, the unincorporated areas of Salt Lake County, West Valley City, Murray City, half of Midvale City, and South Salt Lake City. Paramedic and first responder service was provided by the specific Fire Departments. On August 11, 1999, a tornado struck downtown Salt Lake City at approximately 12:35 p.m.

The first responding engine was Salt Lake City Fire Department Engine 2 with Captain Dennis Goudy in command. He took initial incident command, was replaced by Battalion Chief Bret Rock and then Deputy Chief Steve Higgs.

When the Tornado struck, Chief Higgs was at lunch with Chief Kelly Gee, Chief Mike Mathieu, Department of Health Olympic Planner Brian Garrett, and Salt Lake City Fire Department Olympic Planner Warren James. Chief Higgs responded directly to the Salt Palace Incident Command with Brian Garrett and Warren James following immediately behind. While enroute, Brian contacted Jan Buttrey via cell phone, to alert her of the incident. He was directed to proceed to the scene, keep his cell phone line open and report directly to the incident commander. Upon arrival, Brian found that Steve Higgs had taken command and initiated unified command with Chief Bret Rock, Captain Susan Neely from Salt Lake City Police Department, and a representative from Salt Lake Public Works. There were other command centers established at the Public Safety building, the Avenues, and 4th South.

Brian reported directly to the incident commander and stayed with him as EMS liaison. He was in direct contact with the State EMS office for the duration. Gold Cross Ambulance Field Supervisor Jerry Love reported to the incident commander and was directed to establish an ambulance triage and transport sector at the Wyndham Hotel. He was not incorporated as part of the unified command. All available Gold Cross ambulances were directed to report to the Wyndham for assignment. Because Gold Cross was responsible for providing ambulance service for such a wide area of Salt Lake County, Gold Cross contacted the State EMS Office, requesting that the Bureau stage ambulances from outside the disaster area to help Gold Cross cover the rest of the county not directly involved in the tornado. This process was conducted from the BEMS Office and Brian Garrett informed the Incident Commander that additional ambulances were being staged at the Cannon Health Building to cover the rest of the community and allow him full access to all of Gold Cross' vehicles. In addition, DOH had mobilized (and notified the Incident Commander of its availability) a Disaster Response Unit, filled with additional mass casualty supplies and equipment in case they were needed.

All of this took place within the first 30-45 minutes following the incident. The State EOC, under Department of Public Safety Command, was not fully ramped up until 1 or 2 hours after the incident began. Many of the ambulances staged at the Cannon Health Building were dispatched by Gold Cross into other areas of the valley to respond to calls having nothing to do with the incident itself. Exact numbers regarding ambulance runs are available.

Many times, EMS response does not fit within the confines of establishing an operational Emergency Operations Center. By the very nature of the beast, emergency medical services must be delivered immediately as minutes mean lives. Frequently, the initial EMS operations are over long before State and Local EOCs are up and functional. The State EMS Office is set up to respond immediately to support local EMS operations when requested. This is affected by having an all hazards disaster number for Statewide Support for EMS Agencies and Hospitals (1-866-364-8824 [1-866-DOH-UTAH]). This line is staffed 24/7 by a live body who has the authority to activate resources immediately.

Since that time, the concept of State EMS on-scene liaisons has been built into Bureau disaster plans for all major responses (example: the Sept 14, 2001, train crash outside of Wendover, all plans for Olympic response, including the Walker Bank hazardous materials incident during the Games). This has worked so well, that then Director of Emergency Services, Scott Behunin, incorporated it into the DES response plans as well.

The Firechiefs have suggested that a Statewide Incident Command system should be implemented. That implementation was accomplished prior to the Olympics. Since that time, the state (all Departments) as a whole has adopted and the Department of Health has actively been teaching, the National Incident Command System. This is a Federal requirement for all organizations, both state and local that receive Federal Homeland Security or Bioterrorism preparedness funding. A Mass Casualty Incident Triage System was developed prior to the Olympics with input from many fire agencies within the Olympic footprint and has since been taught and adopted statewide.

DATA COLLECTION, RECORDS REPORTING STATISTICS

Just as any other medical professional must document their patient treatments and create a patient medical record, so must the Emergency Medical Technicians and Paramedics. These records become part of the patients' complete medical record at the hospital. In order to conduct quality improvement programs and to modify curricula or protocols, it is necessary to have access to the prehospital data collected by the EMS personnel. It is also an essential part of a combined data set that links EMS data, emergency department data and trauma registry data to determine if and how patient outcomes can be improved. The data element requirements are approved by the EMS Data Sub-Committee after careful research and coordination with the National EMS Information System (NEMESIS). These data elements consist of basic name, address, and chief complaint, as well as the results of the physiological examinations, and treatment or medications given.

The Department of Health is in the process of developing a new prehospital data collection system that will be available to all providers on-line, and free of charge. We

are working closely with the developers to insure that it will interface with other proprietary systems as well as interface with multiple dispatch CAD programs for the automatic population of some data elements. While it does state within the EMS Administrative Rules that EMS grant funds can be withheld for failure to comply with data regulations, the rule has never been applied. The Bureau of EMS has always been willing to work with the agencies to bring them into compliance.

The fire service is required to send detailed information on all fires to which they respond to the U.S. Fire Administration. Within the past 10 years, the departments are now also required to submit basic information (name, address, and chief complaint) on all EMS calls they respond on. The Bureau is working with the State Fire Marshall's Office as well as our software developer to determine if the fire service EMS report could be automatically generated by the program we currently have in development.

FUNDING AND GRANTS

In 1986, the legislature created the EMS Grants program. The funding formula for the program split the funds into three categories: per capita funds; competitive grants; and the high school training program. The legislature chose this configuration because of the very nature and make-up of the state. Over 75% of the state's population lives within 25% of the land mass of the state. The per-capita portion of the funds (42 ½% of the total) was set aside with the full knowledge that the majority of this money would go to the Wasatch Front communities. On a per capita basis, counties such as Daggett County (year round population of 986) barely get enough funds to make it worth while to write them a check. However, while their tax base is only 986 people, Daggett County is home to Flaming Gorge Reservoir and plays host to millions of visitors each year. In order to provide a quality EMS service, this county (and 24 others) had to be eligible for other funds that their remoteness and lack of population would help them to qualify for. The Per Capita grants are given without restriction to be spent on anything that will improve the provision of emergency medical services, without a requirement for matching funds. The Competitive grants are open to all applicants. They are written for specific items and must be matched with local funds. They are judged by the EMS Grants Sub-Committee, a group representing all aspects of the EMS Community and all parts of the state, based upon a formula determined by location, population, statement of need, and prioritization by the local EMS Council. Much of these funds go to the rural areas of the state, just as the legislature intended. The actual distribution of last years' funding is as follows:

| FY 2005 EMS Grant Funds | | |
|--------------------------------|----------------------|----------------------|
| Total Agency Funding | Rural County Funding | Urban County Funding |
| \$ 1,314,225.00 | \$ 663,463.00 | \$ 650,762.00 |

A complete EMS Needs Assessment was conducted three years ago in conjunction with the HRSA Hospital Bioterrorism Preparedness Grant and the Homeland Security Grants. This led the Department of Health to contract with State ITS to conduct a needs assessment of the communications needs statewide in preparation to provide funding assistance through the HRSA Bioterrorism funding for preparedness. The assessment demonstrated a need for equipment (radios, pagers, etc.) as well as infrastructure (voice

recorders, repeaters, etc.). A meeting was held with DES and DOH and an agreement was made that DOH would fund equipment and DES infrastructure. Each group would use the federal grants to accomplish this worthwhile goal. DOH is now entering into the final year of the project and has purchased equipment for all counties including police, fire, and EMS agencies. DES, on the other hand has been hampered in the process and only able to fund a small portion of the infrastructure because the local LEPC agencies wanting to buy computers and other projects ahead of infrastructure for communications. This has forced DOH to buy infrastructure and push some of its purchases into year four.

SUMMARY

In summary, the emergency medical services system is an integral part of health care and public health. The prehospital providers act as an extension of the emergency department and the healthcare delivery system in general. The standards and regulation of this safety net for Utah citizens, needs to remain within the Utah Department of Health. Coordination with our public safety partners is essential and must continue and we must also partner with hospitals, community organizations and other state and professional agencies, in order to build and maintain an integrated health response system. The Utah Department of Health would much rather build bridges of cooperation than silos of specialty.

The Utah Department of Health's Vision Statement is:

Our vision for Utah:
A place where all people
Can enjoy the best health possible,
Where all can live,
Grow and prosper in
Clean and safe communities.