

ADVOCATES



Testimony of
Richard C. Hunt, MD, FACEP

On behalf of
Advocates for EMS

Before the

Subcommittee on
Labor, Health and Human Services,
Education and Related Agencies

Committee on Appropriations
U.S. House of Representatives

May 14, 2003

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Good afternoon Mr. Chairman and Members of the Subcommittee. I am Dr. Richard Hunt, President of Advocates for Emergency Medical Services, and a Professor and Chair of the Department of Emergency Medicine, SUNY Upstate Medical University, in Syracuse, New York.

I am here today to provide a perspective from the field on the critical need for increased Federal support of emergency medical services through the programs under the Health Resources and Services Administration and the CDC. This is not only important for our nation's ability to respond to acts of terrorism, but also the 25 to 30 million calls to 911 that EMS responds to on an annual basis providing out of hospital care and transport to patients in life threatening conditions.

Specifically, our organization supports the inclusion in the 2004 Labor HHS Appropriations Bill under HRSA of \$25 million for a newly authorized Rural EMS training and equipment program, \$12 million for the trauma/EMS program, and \$25 million for the EMS for children program. We also strongly support the request for the Hospital Preparedness program, and encourage increased funding for that program as well.

WHAT IS EMS?

I would like to begin by providing a summary of what EMS actually is, and why some of our medical professional groups have come together for the first time this year to launch a formal advocacy effort.

EMS represents the intersection of public safety and public health. This role requires EMS to respond to emergencies as a first responder in the public safety capacity, as well as integrate with the health care system, as a medical care provider. EMS systems vary by state, but in general may consist of:

- Emergency medical technicians and paramedics who treat victims at the scene and during transport to the hospital in urban, suburban and rural areas;
- Ground and air ambulance response and transport services;
- 911 call centers that dispatch emergency response;
- State EMS offices that license providers and provide regulatory functions in the state; and
- EMS physicians oversight providing on-line and off-line medical direction.

EMS providers may be public, private, or volunteer, or most often are actually a combination of these types of providers within a state or local area. Public providers may be part of a fire department, a health department, an emergency management agency, or other state or local unit of government. Volunteers often work side-by-side with paid services. It truly is a very unique patchwork for providing critical medical services; but because of this patchwork nature, we do not have a uniform system of public financial support at the Federal, state and local levels. The public may perceive that all 911 medical emergency calls in the U.S. are responded to much like they saw on the 1970's TV program "Emergency". That is not at all the case. In some areas of the country, we have very advanced well supported EMS services with state-of-the-art capabilities. In other areas of the country we are struggling with out-dated equipment, minimal training, recruitment and retention problems, and inadequate service to the public.

The general public expects that a call to 911 in a medical emergency will quickly bring an ambulance, if one is needed, with trained personnel and proper equipment. Unfortunately, the facts of the national EMS system are that:

- 9% of the country does not have basic life support,
- 23% of the country does not have advanced life support
- 25% of the country does not have helicopter ambulance support
- 26% of the country does not have 911, and an emergency call may go unanswered

Rapid response times are critical to an EMS system's ability to save lives. Personnel and equipment resources are essential to provide response times that can save lives. The variability in response times by EMS systems throughout our country is directly related to the support each receives.

In the post September 11 era, as our nation takes action to guard against potential terrorist attacks, the EMS community has observed the attention devoted to "first responders" which has often been defined as police, fire and "others". We are the others. EMS is the third service of first responders. We are often the first ones on the scene, and are the ones that treat illnesses and injuries in the field, and transport them to hospitals.

EMS has the same needs for communications equipment, protective gear, training, planning, and exercises as police and fire. While Congress has provided hundreds of millions of dollars for the first responder needs of police and fire, very little has gone to EMS. We would like to redefine the common understanding of first responders to be "police, fire, *and EMS*" – and to realize a commensurate increase in Federal support for the routine, day-to-day infrastructure needs of EMS, in addition to support for the terrorism-preparedness needs. It is clear to us in the field, that you cannot build a terrorism response system on the back of a failing infrastructure. The basic support that HRSA and CDC programs provide is a perfect mechanism to strengthen that basic infrastructure for EMS with additional funding and guidance.

That is why we formed a coalition called Advocates for EMS. The leadership and support for advocates comes from two principal EMS professional organizations: the National Association of EMS Physicians (NAEMSP) and the National Association of State EMS Directors (NASEMSD). Our organizations' interests are to assure that all components of EMS are prepared to respond effectively to daily and extraordinary emergencies. The leaders of the EMS professional medical community realized that we must take the initiative to raise these issues of EMS preparedness to Federal decision-makers, rather than stand by as the needs of EMS, and most importantly, the needs of the patients, fall through the cracks.

HISTORICAL FEDERAL SUPPORT FOR EMS

The modern EMS system has an unexpected beginning in the Department of Transportation. It originated with a 1966 National Academy of Sciences report, *Accidental Death and Disability: The Neglected Disease of Modern Society* that documented that the American health care system was ill-prepared to address an injury epidemic that was the leading cause of death among persons between the ages of 1 and 37. In the same year, the Highway Safety Act of 1966 established the National Highway Traffic Safety Administration and was given authority to improve EMS, including program implementation and development of standards for provider training. States were required to develop regional EMS systems, and costs of these systems were funded by the

Highway Safety Program. Over the next 12 years the DOT contributed more than \$142 million for EMS system development. In 1981 though, the Omnibus Budget Reconciliation Act consolidated EMS funding into state preventive health and health service block grants administered by the Centers for Disease Control, and eliminated all other funding; resulting in the decline of base infrastructure. Today the CDC preventive health service block grant is funded at \$135 million, and approximately \$8 million is used in the area EMS. The EMS/trauma program at HRSA currently receives \$3.5 million annually, and the EMS for Children program receives \$19.5 million.

EMS PROGRAMS SUPPORTED BY HHS

I would like to highlight three specific HRSA programs that can make a huge difference with relatively modest funding increases.

Rural EMS Training and Equipment Assistance Program

Recent national events have continued to draw attention to the need for communities to have strong emergency medical systems in place. Unfortunately, while the need for effective emergency medical care may have increased, the number of individuals able to provide these services has declined. This is a particular problem in rural areas where the majority of EMS personnel are unpaid volunteers. Training is far more difficult, yet critical because response and transport times are longer in rural areas. Decreased financial support in rural areas compromises these EMS systems' ability to purchase equipment. As rural economies continue to suffer, it has become progressively more difficult for rural EMS providers to recruit and retain these personnel. As a consequence, emergency medical squads are becoming smaller. We respectfully request that \$25 million in the FY 2004 Labor HHS Appropriations Bill for the Health Resource and Services Administration be appropriated to establish the Rural EMS Training and Equipment Assistance Program. Congress recently authorized this program, but no funds have been appropriated.

This program would award competitive grants to State EMS Offices, State Offices of Rural Health, local government, and state or local ambulance providers to improve emergency medical services in rural areas. The fund can be used to recruit emergency and volunteer medical service personnel, training, and acquisition of EMS equipment and personal protective gear.

Trauma/EMS

Trauma/EMS systems are an integral component of our Nation's health and public health infrastructure and an important public safety resource in all states. For a trauma system to work effectively, detailed planning is required so that the system can function as one seamless system of healthcare delivery. Patients are matched, through protocols and medical supervision, with the right facility that maintains the resources who best meet the needs of the patient. Therefore, a State must assess resources and level of care delivery capability of all facilities: trauma centers, urban and rural hospitals, burn centers, pediatric centers and rehabilitation facilities. Standards and guidelines are in place for the entire continuum of care.

HRSA has recently completed an assessment survey of each state's trauma system. It indicates that only one-half of the states have some of the key elements of a fully functioning trauma system; only 8 have all elements; and 15 states have only the authority to designate trauma centers, but no program operations. The 1999 IOM report, *The Burden of Injury*, stated that without federal leadership states fail to continue investing in their trauma systems. Therefore, Advocates for EMS respectfully recommends increasing the

HRSA trauma/EMS program from the current level of \$3.5 million to \$12 million in fiscal year 2004 in order to strengthen the nation's trauma system, and thereby strengthen our nation's EMS system.

Emergency Medical Services for Children

Each year over 31 million children and adolescents are seen in emergency departments throughout the nation. Fewer than half of the hospitals (46%) with emergency departments have the necessary equipment for stabilization of ill and injured children. Systems are not in place to assess and evaluate pediatric emergency care, with only 9 out of 27 states that even have statewide computerized data collection systems that produce reports on pediatric EMS using statewide EMS data. In fact, no more than 11 states have pediatric guidelines for acute care facility identification to ensure that children get to the right hospital in a timely manner.

The Emergency Medical Services for Children (EMSC) demonstration program, which began in 1984, was designed to ensure state-of-the-art emergency medical care for ill or injured children and adolescents. It covers the entire spectrum of pediatric emergency medical care including primary prevention, acute care, and rehabilitation. The EMSC program provides grants to States to improve existing EMS systems and to schools of medicine to develop and evaluate improved procedures and protocols for treating children. The September 11, 2001 terrorist attacks and threats of future bioterrorism make it all the more critical that the medical systems in the United States be prepared to provide appropriate life saving services to infants, children and adolescents. We respectfully request that this program be increased to \$25 million.

Related Programs

We also join other health organizations in supporting a request of \$50 million to expand access to automatic external defibrillators through the HRSA Rural and Community Access to Emergency Devices programs. The need for these devices is great given that approximately 250,000 Americans die from sudden cardiac arrest annually. Because survival rates drop by up to 10 percent with each minute that passes, victims of sudden cardiac arrest must receive treatment within minutes or death is almost certain. Currently, out of hospital survival rates for sudden cardiac arrest remain in the single digits. Communities with aggressive AED placement plans have increased local survival rates dramatically, and the American Heart Association estimates that placing these devices in more public settings could save 50,000 lives each year.

In CDC, Advocates for EMS support a level of \$210 million for the CDC Preventive Health and Health Services block grant, and \$178.4 million for the National Center for Injury Prevention and Control. At the current level of \$135 million for the prevention block grant, approximately \$8 million is used by States to support EMS systems, and an increase would allow States to meet their most urgent EMS system development needs. An increase of \$30 million for the National Center for Injury Prevention and Control would strengthen the capacity of state and local health agencies to prevent injuries and support extramural public health research to conduct and translate science into practice. Additional funding would expand public health support for injury prevention programs in all 50 states and ensure provision of necessary tools for developing effective injury prevention programs in our communities. The multi-disciplinary field of injury prevention and control is a collaborative effort among a broad spectrum of people and organizations including schools of public health, medical schools, emergency medical systems, and trauma centers. Expanded support would allow these injury researchers to improve current methods and develop new ways to prevent and treat traumatic injuries and reduce disabilities.

Advocates for EMS also support increased funding for the HRSA Hospital Preparedness program, and want to thank the Members for including report language in the 2003 appropriations bill that encourages states to assess EMS needs and develop a plan to address those needs. The spirit of this language has been incorporated into recently released HRSA grant guidance, and will serve as an excellent catalyst to initiate the process of strengthening of EMS systems.

SUMMARY

As you can see, there are many programs in HRSA and CDC that play critical roles of support for EMS systems. Unfortunately, even in these times of terrorism preparedness, most of these programs have not seen funding increases in recent years.

We cannot ignore the expectations of the public. Public safety is a three legged stool including police, fire, and emergency medical services. Currently, EMS is unable to provide an adequate emergency medical response to daily emergencies or to terrorism without an appropriately funded national initiative. Until we agree on a baseline level of emergency medical service response for daily emergencies, we will never have the infrastructure in place to respond to the extraordinary emergencies like we saw on September 11th. I urge the Members of this subcommittee to carefully consider these needs, and make every effort to ensure that Federal support equally addresses all three life-saving services for the public.

In closing, I would like to thank you, Mr. Chairman, and Members of the Subcommittee for your attention to our testimony, and would be pleased to answer any questions that you may have. Thank you.

**Biography of
Richard C. Hunt, MD, FACEP**

Dr. Hunt received his Master of Science degree in Anatomy from the Medical University of South Carolina. He completed his Doctor of Medicine at East Carolina University, and his residency training in Emergency Medicine at Wright State University where he was Chief Resident. From 1988 to 1998 he was a member of the faculty of the Department of Emergency Medicine at East Carolina University. During his tenure there he served as medical director of the helicopter and ground critical care transport service, and subsequently as Vice Chair of the Department of Emergency Medicine. In April 1998 he joined SUNY Upstate Medical University at Syracuse as Professor and Chair of the Department of Emergency Medicine.

Dr. Hunt has authored many publications on emergency medical services, air medical transport, and motor vehicle crash injury research. He was a member of the ACGME's Residency Review Committee for Emergency Medicine from 1986-1988. He served as Vice Chair of the Commission on Accreditation of Air Medical Services, is a past chair of the Trauma Care and Injury Control Committee of the American College of Emergency Physicians, and is the liaison to the American College of Surgeons Committee on Trauma. He served as the Principal Investigator for Upstate's three-year "Wireless Enhanced 9-1-1 Demonstration Project," which was supported by the National Highway Traffic Administration and Intelligent Transportation Systems – America and — as president of the National Association of EMS Physicians from 2001 to 2003 — he led a joint effort of that organization, the American Public Health Association and the National Association of State EMS Directors to develop the new "Basic Medical Response to Terrorism" course. Dr. Hunt remains active in the national leadership of emergency medicine and emergency medical services, currently serving as the president of Advocates for EMS.