Emergency Dept News Feb 1981

EMS Funding Still A Question Mark

ST. THOMAS, V.I.—Funding for Emergency Medical Systems under the new Reagan administration was still up in the air as more than a hundred physicians and hospital administrators met here for an "EMS Systems and Trauma Center Development" course sponsored by the Maryland Institute for Emergency Medical Services and the University of Maryland School of Medicine.

However, so far so good.

"At present there is no indication of any specific programatic changes in my area or as far as I know in other health areas," Dr. David Boyd, director of EMS Systems for the U.S. Department of Health and Human Services, told EDN. "From what I read in the press, the new administration is going to look at welfare programs and some of the recipients of special entitlement, but we have seen no indication of what they intend to do to categorical programs.

"The present Carter budget went in at around a $30 million mark, so it's business as usual until we see what comes in. Now, obviously the Reagan administration is going to come in with their own 1982 budget. But I'm optimistic because we've had good support from this program by key Republicans...Schweiker has always supported our program in difficult times; Bob Michael has always been a real supporter of our program and he's now the majority leader; also Rhoades in Arizona and other key Republicans have given us a lot of support for this program."

Not Enough Dollars Yet

Boyd told EDN that he would like to expand the system. At the moment, only a few states—such as Maryland and Illinois—have statewide EMS systems. "And that's for two reasons. One is that we had very good leadership in those states—physicians said, 'I'm going to do this...,' through myself, and Dr. Cowley in Maryland, and I haven't seen that replicated elsewhere.

"The other thing is that our funding has been on a region-by-region basis because of budgetary limitations, so I'd like to have it done statewide, but we haven't had enough dollars to get out there."

Another view on the outlook for funding of EMS systems in the future was expressed by attorney Harry Teter, a consultant to the Maryland Institute for Emergency Medical Services (MIEMS). He told the meeting that "for the last two years funds for EMS were in danger of being wiped out, and it remains to be seen what will happen now."

Teter said the lack of support has stemmed from "ignorance" on the part of legislators, which means physicians are going to have to step in and educate them. The enabling legislation will die if not enough effort is made to have it renewed next year.

The importance of the legislation is that it provides "seed money" for the establishment of EMS. Without such funding, he said, the aim of having EMS nation-wide is probably only a dream.

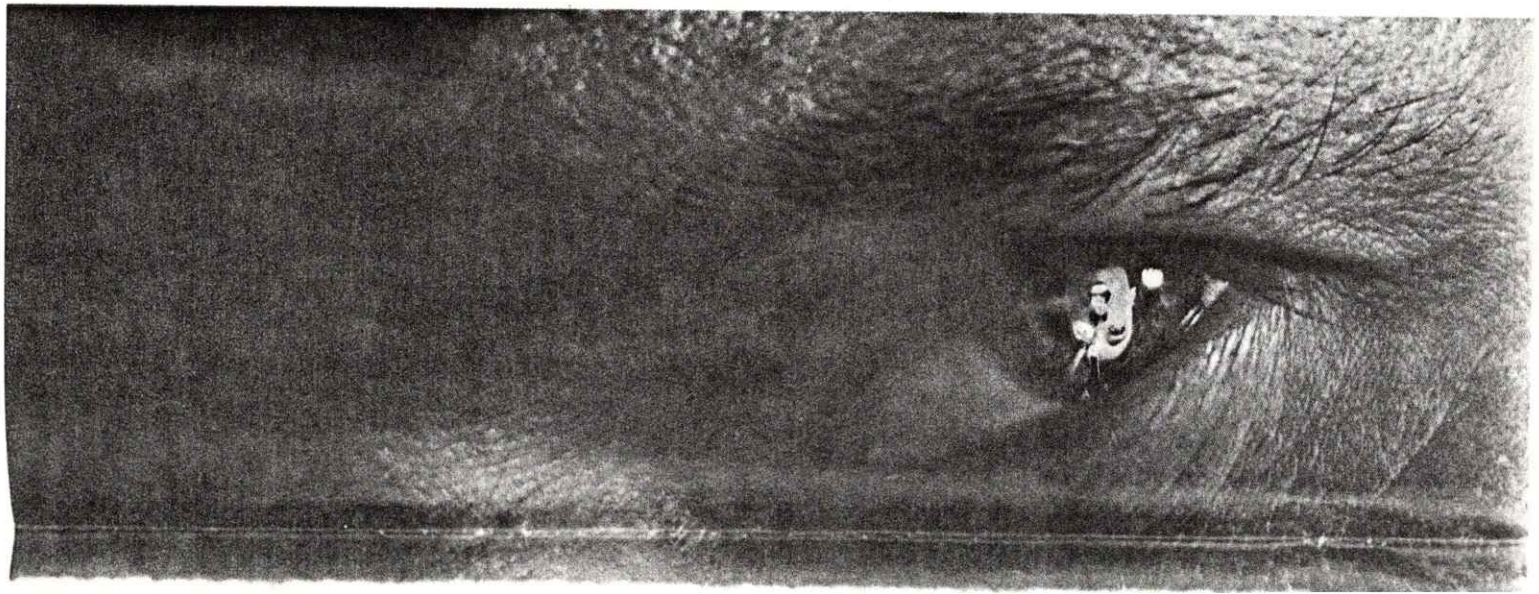
What To Do In Transfusion vs. Church Cases?

by Tom Sellers

ATLANTA—The use of autologous and frozen blood should be considered by physicians when confronted by a refusal of a Jehovah's Witness patient to accept normal blood transfusions, an Augusta physician says.

Dr. M. M. Fatteh, director of the Blood Bank, Medical College of Georgia, discussed the problem in the December 1980 issue of the Journal of the Medical Association of Georgia.

"A patient has the right to withhold his consent to lifesaving measures," Fatteh said. "Whether we as physicians like this or not, we have to accept it. Yet, blood transfusion is just one facet of therapy. A physician may not refuse to treat a patient who does not accept his personal convictions in a life-threatening situation. He is morally, ethically, and legally obligated to provide the remaining facets of the medical care



EMERGENCY SERVICES

Outlook For EMS Guarded But Favorable

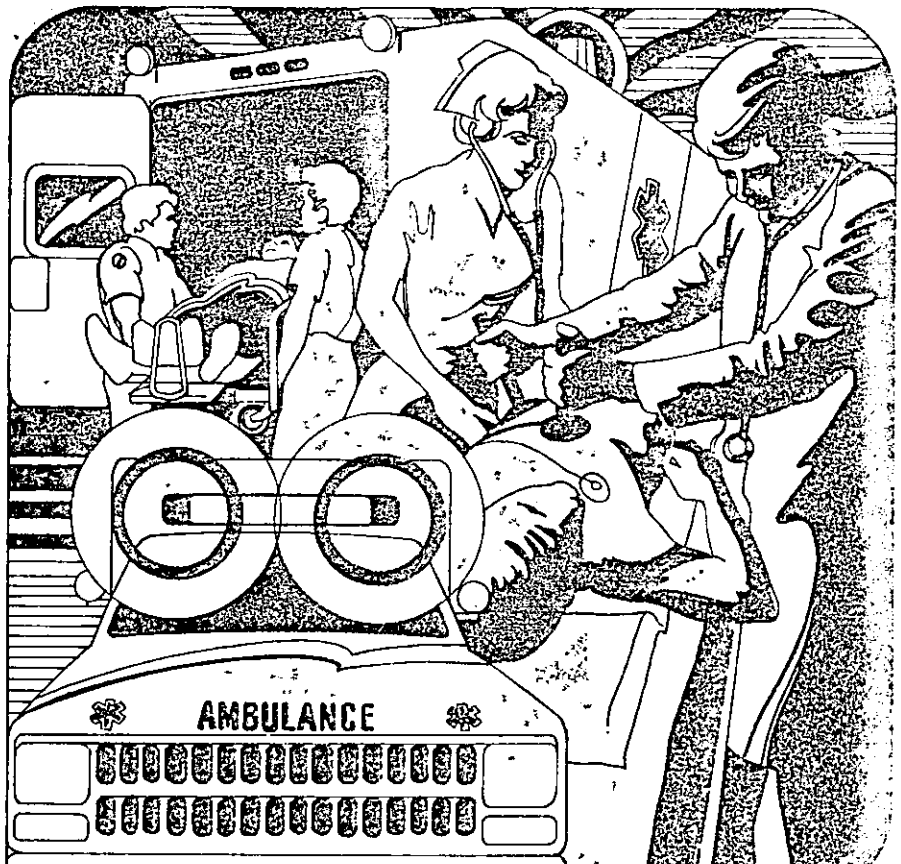
by Glenn Richards

There is widespread agreement that emergency medical services exist today in greatly advanced form. The question of whether first-rate EMS systems can be achieved nationwide remains, however. The answer appears to depend more than ever on state and local governments.

The Division of Emergency Medical Services of the Department of Health and Human Services is nearing a date with extinction. This is the agency that for eight years directed the federal effort to lay a wall-to-wall carpet of emergency medical services (EMS) systems across the United States. The EMS division barely is at skeletal strength today, and its demise, to come with the end of the federal fiscal year September 30, figures to be anticlimactic. Congress decided a year ago to let the states take over the job.

How far along the nation is toward having an effective and efficient, handle-all-comers at-all-hours EMS operation appears to be half-way at most. "I would say about a third of the way," ventures R Adams Cowley, M.D., trauma care pioneer and director of Maryland's EMS program. His estimate is not atypical.

Glenn Richards *is a field editor of* Hospitals.



Probably everyone involved in EMS agrees that great strides have been taken in the past 10 years. Whether the country as a whole obtains life-saving protection now largely depends on the EMS systems themselves, whether they can secure adequate state and local funding, overcome operational problems, and form networks on their own.

In passing the EMS Systems Act of 1973, Congress never intended that the federal government would forever be in the business of establishing and improving EMS systems. Rather, the law provided seed money in the expectation that, once an EMS system was in place, it would be supported by the communities served. Congress reauthorized the federal program for three fiscal years in 1976, and three more in 1979. However, in the philosophic upheaval that produced the Omnibus Budget Reconciliation Act of 1981, Congress took away the EMS program's categorical grant, and instead, gave the states a block of funds for EMS and such other programs as fluoridation, high blood pressure, home health, and rape crisis. In effect, the states were given near-complete discretion for EMS funding.

What the prospects are for states to support the continued development of EMS systems is "a question that we've all been asking ourselves," says Susan McHenry, president of the National Association of State EMS Directors. Administration of the block grant covering EMS rests with the Centers for Disease Control (CDC), and Tom Ortiz, a CDC spokesman, reports, "We really don't have a handle on how much money is being expended on EMS by the states." States are required only to provide a "reasonable" amount of funding to EMS systems that were receiving categorical grant monies in fiscal year 1981. However, the states are not required to report how the block grants are being spent.

For this last year of the HHS/EMS division's authorization, the program's staff has been cut back to the director, David Boyd, M.D.; his first lieutenant, John Riordan; and a secretary. When it administered categorical funds, the division had a staff of 13 in its headquarters and 29 in regional offices. During those eight years of categorical funding, the federal government spent $309 million under the EMS Systems Act. "Probably the program had completed about 40 percent of its activity" before categorical funding was removed, Riordan estimates.

Between 1974 and 1981, 303 EMS regions were designated across the country. The EMS Systems Act allowed each qualifying region, or system, to progress through five years of funding: an initial year of planning, two years of establishing and operating basic life support (BLS) services, and two years of expanding and improving advanced life support (ALS) capability. Fifty-seven regions (19 percent) finished the five-year cycle and therefore were considered by the HHS/EMS division to be complete. Another 79 (26 percent) were in the ALS stage, while 112 (37 percent) were in the BLS phase. Fifty regions (16.5 percent) had advanced only to the planning stage, and five regions had received no funds. So, while the federal program only finished what Riordan calls 40 percent of its activity, he believes "the base was established for completing the rest of the program."

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The federal drive appears to have ignited considerable state and local spending on EMS. The 1973 law required that hefty portions of an EMS region's costs be financed by other than federal funds. Later amendments reauthorizing the program ordered the entities seeking federal funding to ensure that there would be continued financial support after federal funding concluded. Riordan's guess is that state and local governments have spent seven or eight times the amount of the federal contribution on EMS.

A similar influence on state and local funding has been wielded by the Department of Transportation's (DOT) EMS program, which is geared to emergency transport and prehospital care. Leo Schwartz, chief of the EMS division of DOT's National Highway Traffic Safety Administration, reports that the DOT money being spent on EMS by state and local governments accounts for only 10 to 22 percent of the total of what these governments spend on EMS. DOT has provided $1.175 billion for highway safety, of which the states have designated roughly $140 million for EMS.

A greatly advanced part of EMS is the prehospital component. Only 10 to 15 years ago, it was common for the local mortician's funeral hearse to double as the community's ambulance, and few ambulance attendants were adequately trained for the job. Only rarely was there radio communication between the ambulance and the hospital emergency department.

Today, the country is served by more than 350,000 ambulance attendants, over 80 percent of whom meet the federally recognized standard for emergency medical technician-ambulance. Of the 27,500 ambulances in operation, 40 percent meet federal specifications, 80 percent carry equipment suggested by the American College of Surgeons, and in more than half of the vehicles, the attendants can radio the hospital emergency department.

Like many others in the field of emergency medicine, H. Arnold Muller, M.D., president-elect of the American College of Emergency Physicians (ACEP), believes that "overall, EMS is much improved over what is was." Muller, who also is secretary of health for Pennsylvania, thinks that EMT care in particular has greatly advanced. "Ten years ago. EMT care was just coming into being in Pennsylvania. Today, we have over 30,000 trained emergency medical technicians," he notes.

Besides ambulance personnel being far better trained, communications

systems are more highly developed, he says. "It used to be commonplace for the ambulance to come unheralded to the hospital. Notification makes all the difference in the world," he says.

Muller says an important change has been the development and recognition of emergency medicine as a medical specialty. "Full-time emergency physicians are taking over the work once done by physicians part-time," he says. ACEP has over 10,000 members, and it is estimated that there are 14,000 emergency physicians in the United States. "Something that has really caught on fire in the late 1970s and early 1980s is the development of residency programs in emergency medicine," he adds. There are now 60.

Cowley, who is recognized for advancing effective new methods of trauma treatment and for establishing one of the finest trauma centers, the Maryland Institute for Emergency Medical Services (MIEMS), agrees that EMS today "is a hell of a lot better than what it was," but he believes the nation is saddled with an EMS "nonsystem" that is "grossly inadequate" for handling the trauma load.

For one thing, Cowley contends, the old Department of Health, Education, and Welfare viewed the EMS program as "a small project," gave the EMS division less money to spend than Congress appropriated, and provided director Boyd with a minimal staff "according to what had to be done." (Boyd was unavailable for interviewing for this article.) Cowley says Boyd had great difficulty gaining participation in the project because "there was so much turf-defending by our colleagues in the hospitals and by all the people involved." Consequently, Boyd's hope of achieving a wall-to-wall EMS network by having the various, contiguous regions grow and coalesce "didn't happen," Cowley says.

With the HHS/EMS program over, attention is turning to what the states are doing. "A majority of the states have made pretty good headway toward establishing EMS systems," McHenry says. In urban areas, particularly, there are "some pretty good systems in place," a description she says does not apply as well to rural areas.

In Pennsylvania, for example, some EMS regions are highly developed while others are not, according to Muller. He says one reason for the variance is that some areas depend heavily on volunteers, whereas the systems are paid for in the cities. The prospects for state funding of EMS under the block grant are "reasonably good" in Pennsylvania, although the grant is less than what had been received under the various categorical grants that were combined, says Muller. Pennsylvania agreed to apportion the block grant this year according to the previous levels of federal funding. Next year, however, there will be flexibility to the apportionment and therefore competition among programs, Muller points out.

In Maryland, EMS funding under the block grant almost is what the program had been receiving before, according to Cowley. But he thinks most states are going to use the money to put out bigger fires. "If, for example, you owe Medicare so many millions of dollars, that's where most of that block grant is going to go," he says. "EMS is a new kid on the block, and it probably can't do as well in most states as the others that are competing for the same money."

A similar question is how well those EMS systems have fared that have completed their five-year cycles of federal funding. At HHS, Riordan says, "We don't know of any that have failed. Anytime you finish a federal program I'd be surprised if you didn't remove some of the toots or whistles that maybe we helped you obtain. So I would expect there to be some revamping of the programs and reprioritizing."

In Delaware, though, the state's EMS program "hasn't done too well" since federal funding ended two years ago, says Charles Nabb, director of the EMS state office. All the program staff, except Nabb, had to be laid off. The program had completed four years of federal funding but could not make available the data required for fifth-year support. In June, Nabb was awaiting the outcome of state legislation "that would establish our EMS program on a good foundation by using state funds." With federal funding, Delaware got as far as trying to expand ALS service to the state's rural areas. "There's a lot to be done," Nabb says, citing the need to evaluate existing critical care capability, designate trauma centers, make ALS and the "911" communications system available throughout the state, and establish mutual aid agreements with other states.

In some fortunate states, a leading

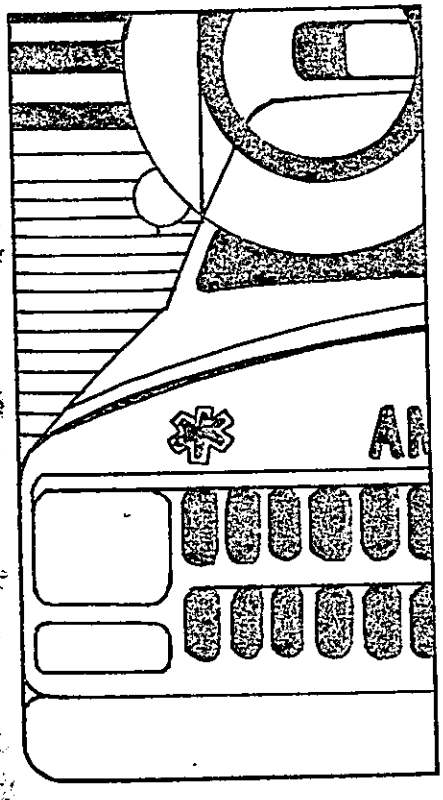
In some states, a leading politician has taken an interest in EMS.

Comprehensive transfer agreements between facilities need to be established.

politician will take up the gauntlet on behalf of EMS. That happened in Maryland when a close friend of former Gov. Marvin Mandel was saved by a trauma team. As a result, the state increasingly became involved in EMS as the program neared the end of federal support. "Sometimes all it takes is to have one interested politician, a legislator or mayor, for instance, express a strong interest in this," observes Pennsylvania's Muller.

Vermont's EMS program, however, had relied totally on federal funding, at $325,000 a year. When that support ended over a year ago, staff had to be laid off and regional EMS offices closed. Since then, the state has provided $145,000 a year, and "in terms of goals and objectives, things are the same, surprisingly," reports Diane Neill, state EMS director.

She believes Vermont has an EMS system 100 percent in place, although the system does not conform with the 15 system components mandated in the federal EMS guidelines. "That ideal is not feasible in a rural state like Vermont," Neill says. For instance, trauma centers have not been designated because most Vermont hospitals are too small to support that capability. However, two medical centers, one in neighboring New Hampshire, are acting as trauma resources for the state. Presently, Vermont is trying to test the quality of ambulance personnel, 95 percent of whom are volunteers, and yet retain the number of existing volunteers.



Like Pennsylvania, California is a state that plans to use its block grant to fund EMS on the same basis as the federal categorical grants did. In addition, "a small amount of state monies are going to match local funding to make sure that what was established under the federal program doesn't collapse," George Moorhead, deputy administrator of the California EMS authority, says. About one-third of the state's 15 EMS regions completed federal funding, while some of the rest reached the first stage of ALS funding. "Most places have a pretty good basic system. The problem is to make the systems more organized and coordinated," Moorhead explains.

Toward that end, the EMS authority is drafting regulations that would define "basic" and "desirable" categories for EMS systems. The agency also is trying to classify patients according to eight different types of conditions and four levels of severity.

"We're trying to make sense as to the number of patients in an area and what it takes to put an EMS system in place," Moorhead says. He also says that comprehensive transfer agreements between facilities need to be established and that more accurate categorization of hospitals by their emergency care capabilities is being attempted.

The designation of hospitals as trauma centers capable of treating the worst-injured patients continues to prove a problem for EMS in many areas. According to Alexander Hering, M.D., director of the American College of Surgeons (ACS) trauma department, what needs to be done is for "people involved in hospitals and townspeople, fire departments, police departments, and city governments to accept that organization and preparation is a

Hering feels that some communities might be better off with "trauma complexes" using three hospitals, while in other communities it might be better to have one trauma center. One problem is that the matter of evaluating the effectiveness of hospitals providing EMS is still being studied. "At the moment, there is a lot of gut feeling that trauma centers are the thing to do, but this is contrasted by other hospitals with crackerjack people who are doing just as well," he points out. ACS is continuing to evaluate its own recommendation that trauma centers be university teaching hospitals that see 500 to 1,000 seriously injured patients a year, he says.

Cowley says that not every EMS region needs a sophisticated trauma facility like MIEMS at its center. Yet he believes every state does, good thing and that you have to select certain hospitals for the treatment of certain patients. Not everyone accepts that principle." Hering says he knows of no instances where "the redirection of trauma cases has resulted in a financial loss to an institution." That possibility, however, is what hospitals fear, he says.

"not just for the service but also for the teaching and research that has to go with it." Around these "highly sophisticated" centers should be 150 "satellite centers doing strictly service work with the objective of providing excellent care," he says.

Bruce Sutton, executive director of the American Trauma Society, says some kind of standardized designation process must be established throughout the country. "States are not getting their EMS systems developed fast enough," he says, in part because designating standards and designating agents within states are lacking. He also blames "politics between hospitals and a general misunderstanding of the economic significance of categorization."

Currently, the nation has about 230 trauma centers. They are rated in levels I, II, or III by ACS criteria on optimal care of the seriously injured. There are some 80 level I facilities, but, while a city like Washington, DC, has four level I hospitals, 11 states are without any kind of trauma center.

As for state EMS funding, McHenry, who not only heads the association of state EMS directors but also is Virginia's EMS director, predicts that EMS funding will be "pretty tight" for the next couple of years but fairly secure because of the block grants. She fears that after the block grants expire, the EMS programs will be in serious trouble if additional state funding has not been obtained.

Cowley says many states and cities finally have realized that it is time "to get the burr under their saddles and get busy and start looking locally for money to keep this [EMS] thing up." In that regard, alternative means of funding EMS systems are being explored. McHenry says the EMS directors' association favors an approach taken in Mississippi, where a new law imposes an additional fee for the support of EMS on persons committing hazardous, moving traffic violations.

One facet that states are not likely to support is EMS research, according to Lawrence Rose, M.D., associate director for medical research at the HHS National Center for Health Services Research (NCHSR). The center, which oversaw EMS research under the categorical grant program, "had a difficult time developing an EMS research program," Rose says. "EMS is an action-oriented field that doesn't depend on research for its existence. The field had a difficult time slowing down enough for scientists to get a handle on what's happening. And by the time they would get a chance to look at it, it had already changed."

Another problem is that the number of researchers able to obtain the right data for EMS research is small, Rose says. He thinks states are not in a position to employ researchers from out of state.

Because EMS are "extraordinarily expensive services," research is critical if the limited resources are to be effectively spent, he argues. "Without this kind of information, state and county officials will have a harder time making choices among all the different kinds of health activities clamoring for money," he predicts.

Rose says NCHSR partially managed to achieve a method of evaluating EMS systems. "For some kinds of conditions, we have some ways to approach the problem," he says. "We have a hammer to hit the nail, but we don't hit the nail that often."

An encouraging sign for the future of EMS, however, is that all states possess the ability to run an EMS program, according to Riordan. "Ten years ago, not more than two or three states had an EMS capability at the state level. Now in all 50 states, although it varies in size and quality, there is an EMS capability," he says.

Why some EMS regions are far advanced and others lag behind, though, lies in "some combination of local citizens' desire to have an EMS system and the motivation of political leaders to address the problem," Riordan suggests. "It also calls for very strong leadership by the medical community and the participation of volunteers," he adds.

Such acceptance among doctors is catching on, according to Cowley. "It takes a lot of guts for a doctor to use our system, to give his patient up to a paramedic in an ambulance or helicopter to go to a place we designate," he says. Maryland doctors have seen the results of the system and now accept it, he says, adding that the medical establishment as a whole is "rapidly changing its views" on trauma treatment methods widely considered controversial only a few years ago.

Both McHenry and Cowley see a possible salvation for EMS in organizations such as the EMS directors' group or the American Trauma Society, of which Cowley is incoming president. The withdrawal of federal involvement "has made associations like ours even more important in the last couple of years," McHenry says. Cowley says the trauma society is trying "to make the public aware that trauma is the number one killer of young people and the third killer overall. If we can get something moving at the grass roots level, the public is going to demand that more money be spent in that area," he says.

Cowley himself fights for trauma care to be given the kind of support accorded cancer and heart disease treatment. He contends that not much progress can be made in the treatment of cancer and heart disease until basic discoveries are made about "why cells become malignant and divide like they do" and "what makes blood vessels get hard." Yet, "the thing about trauma is that you don't need to discover anything. The capabilities are there. All you need is a system to get the patient to the right place," he says.

As for EMS systems forming a national network on their own, Cowley says it already is beginning to happen. He notes that eight Eastern states are working together on interstate problems, such as establishing reciprocity and the legal liabilities involved when EMTs cross state lines. "We also are getting to the point where we want to talk about setting up trauma networks. And other states are asking to join the program," he reports. ■