LONG-TERM REGIONAL ORGANIZATION OF EMS

James O. Page, J.D.
On January 23rd, 1976, Mr. Gregory J. Ahart, representing the U.S. General Accounting Office, issued a statement on the EMS Systems Act of 1973 to a Subcommittee on Health of the U.S. Senate. The statement was prepared following a GAO review of the activities of 12 EMS grantees who received federal support for either planning, establishing, or expanding EMS systems in their geographical areas. The statement was an attempt to provide the Senate Subcommittee with insight into what the GAO sees as progress and problems being experienced in developing regional EMS systems.

In describing problems perceived by the GAO, Mr. Ahart referred to difficulties in establishing and operating systems on a regional basis. He further stated that problems being experienced by the regional management entities will become more critical when federal funding, as called for in the Act, stops.

In attempting to analyze this perception of organizational problems, we should first attempt to make certain that we are all discussing the same issue from a mutually understood viewpoint. What is a system?

We have all read the law and the implementing guidelines. We have seen the definitions of an EMS system. But, given the substance and implications of the GAO report, there may be some conflict between what the Congress intended, how HEW interpreted the Act, what the grantee implementers see as a system, and what the GAO currently envisions.

The GAO states that the act and implementing guidelines provide for bringing together existing resources into a regional system operated directly or indirectly by a single management entity. Operated by? A single management entity? What does the GAO visualize when they refer to a single management
entity which directly or indirectly operates a regional EMS system? How direct? How indirect?

Much of a practicing lawyer's time can be spent in analyzing statutes. Application of a law to specific factual circumstances nearly always raises questions of statutory intent. What did the lawmakers intend when they composed the language of the law?

Unfortunately, we have neither the time nor the forum to adequately investigate the precise intent of the Congress in passage of the EMSS act of 1973. Perhaps an alternative is to view, in general terms, the end results the Congress was seeking. That is, improved emergency health care services.

The GAO report acknowledges that, with the aid of Federal funds authorized under the Act, communities throughout the country have been able to upgrade their EMS resources. But the report continues by identifying certain "problems." Our question is whether those alleged "problems" are truly relevant to the Congressional goal of improved emergency health care services.

For example, the GAO contends that regional management entities are having difficulty identifying firm sources of permanent financing of "administrative" and "operating" costs that are initially borne by Federal grant funds. In addition, it is contended, these regional management entities have little control over the level of emergency medical services being provided by local governments and EMS providers.

The validity of the GAO report must be questioned when it is noted that "operating costs" are identified as monies being used to purchase central
communications lines or towers, equipment, etc. It is our impression that those are implementation monies—capital funds which are intended to upgrade EMS resources, create higher public and industry expectations, and eventually create such community reliance on the system and its hardware that local governments will find it politically necessary to continue operation and growth of the system after a departure of federal monies.

If we can distinguish "operating" costs from "administrative" costs, we should then be able to look at future financing needs before decrying the apparent absence of identified funding sources. What administrative costs will be necessary in a typical region at the conclusion of the five years of federal funding?

We suspect that the GAO has visualized a bureaucratized and institutionalized agency which would organize, reorganize, control, manage, fund and operate all the services that fall within EMS in a region. At the very least, such a profile would superimpose a strong regional management entity over local governments and local services. Obviously, such an EMS bureaucracy would be expensive and would require firm and long-term sources of finance.

But is such a superagency necessary to accomplish the Congressional goal of improved emergency health services? There is not much evidence to indicate that large, all-inclusive bodies or agencies are a desirable path to improved service of any variety. Nonetheless, there may be regions currently funded under the Act where such a structure is deemed an appropriate goal. If so, long-term administrative costs can be viewed as a
funding need for which firm sources of financial support should be developed during the period of federal funding.

However, the general thrust of the GAO report is to question the entire national program for the inability of several grantees to line up long-term funding sources for which there may be no need.

The current political climate in America is heavily stacked against creation of new levels of government - EMS or otherwise. Against this background, the GAO report criticizes the coordinating and advisory role assumed by most of the grantees. This criticism fails to recognize that local governments and service providers will only reluctantly and begrudgingly allow themselves to be coordinated and advised. Efforts by some new and uninvited agency to manage and control local EMS resources will be met by reactions ranging from fury to total disregard.

The report states that because of their responsibility for, and financial interest in, the provision of emergency health services, local governments and EMS providers are reluctant to relinquish management and operational control of their resources to the system's designated management entity. The GAO identifies this as a "problem." We see it more as a problem of form than of substance.

Did the Congress truly look for revolutionary transfers of management and operational control to hundreds of grantee agencies? Once again, we must revert to the basic Congressional goal of improved emergency health care services. Can those services be improved without such a transfer of management and operational control?
In response to this question, we have once again reviewed the list of fifteen basic requirements for an EMS system. With regard to each of the requirements, we have asked, "Can it be satisfied by a coordinating and advisory body or will it need a region-wide, unified EMS management and control agency?" We are convinced that in most cases, the general goals of the Congress can be met without force-fitting another unwanted governmental or quasi-governmental administrative entity into the already strained fabric of the health care system.

But this conviction relies heavily on the personal skills and credibility of the current grantees as they work with the federal resources which are temporarily available.

The GAO report includes capsule reports of episodic incidents of difficulty and failure experienced by certain of the grantees who were site-visited. In one case, for example, it is noted that a local referendum to support operating costs of advanced life support teams had ended in defeat. In another case, it was reported that a demonstration project in its final year of federal funding has failed to secure local government commitments to continue a regional telephone communication system, data collection, and system management. In still another case, the report pointed to one project's inability to reduce the excessive number of ambulance vehicles serving the region.

In its report to Congress, the GAO should have balanced these episodic incidents with a realistic view of the environment. First, let us recall that the federal money has now been working for EMS system development less than two years. Many of the projects have moved from the planning
to implementation stages only during the last year. There has been no public outcry for reorganization, development and improvement of EMS resources. Most local government elected officials had never heard of EMS, much less Public Law 93-154, until the arrival of a health planner supported by something called a "1202" grant. At the same time, they have been confronted by the economic outfall of a severe recession.

The GAO should attempt to recognize that public policy is usually the result of political forces. Political forces often represent community demands and consensus. Most communities have yet to achieve consensus on EMS as a priority public service issue. In very few communities has there been any noticeable public demand for creation of a regional EMS system. Until public demand presents a strong consensus to political representatives within the community, there will be no public policy sufficient to bring about basic change in management and control of local EMS.

Even where public policy would allow creation of an EMS superagency, we wonder whether such an agency would serve the long-range needs of people in the region, or the general goals of the Congress. The nation's experience has shown that the security and comfort of a big, deeply-entrenched bureaucracy frequently leads to passive and insensitive response to changing needs. There is something to be said for the built-in competitiveness of the multiple service providers operating in most of the EMS regions - even if they do have too many ambulances and they are painted different colors.

Returning to our basic proposition, we feel that in most regions the list of fifteen basic requirements can be met without the imposition of a new
level of management authority and control. We must presume then that the GAO, or the Congress, or both, have missed the mark in speculating on the size, shape, function and effect of the regional EMS system at the terminus of federal funding.

As stated, the more practical profile of a long-term EMS system will be determined largely by the personal skills and credibility of the current grantees. Such qualities, if appropriately and persistently applied, can produce a higher degree of consensus for improved emergency health care services. If skillfully managed - manipulated, if you will - such a consensus can be converted to public policy. That public policy can reflect a local government commitment to long-term improvement and operational support for emergency health care services.

At best, this process is inexact and time-consuming. It will usually involve setbacks - such as an occasional loss of a referendum election. It may produce only a tenuous coalition of service providers, each reluctantly consenting to policy changes which involve infringements to territory, authority and role. Most likely, it will be difficult for a federal accounting agency to comprehend and appreciate during brief site visits. But, given the current public policy environment, it may be the best configuration we can hope to achieve.

The heart of the regional EMS system may well be its advisory board - the EMS Council or Committee. In many areas, it is likely to be the organizational and management remnant of the five-year sequence of federal funding. In many areas, it is likely to reside within the Health Systems Agency.
What sort of legacy will the EMS Council or Committee have to build on at the conclusion of federal funding? Once again, that depends on the personal skills and credibility of those currently engaged as grantees. Hopefully, there will be a higher degree of consensus for improved emergency health care services throughout the region. Hopefully, that consensus will have produced public policy which reflects local government commitments to long-term improvement and operational support.

There are still volunteer rescue services that see EMS as little more than extrication. There are still physicians who lack the skills of basic life support. There are still city managers who see EMS as a contract for ambulance service. There are still fire chiefs whose perceptions of EMS are limited to some ill-defined paramedic concept. There are hospital administrators who still see categorization as a threat. And critical patients all over America are still being delivered to the wrong hospitals. These are the issues with which we must deal while we have the benefit of federal resources. They are issues of perception. They are issues which must take precedence over concern for size, shape and power of a management structure which would inherit the system and its problems.

Capable and credible grantees should be working to change viewpoints. They should be using every mind-bending tool at their disposal to lead the volunteers, the physicians, the city managers, the fire chiefs, the hospital administrators and others out of their self-limited images.

An improved understanding of EMS as a system is likely to produce the desired public policy commitments from local government. Long-term
organization and management of those commitments is likely to rest with an EMS Council or Committee. But we must recognize the independent nature of most Americans. Plainly, they don't want to be managed or organized.

Given the reality, what mechanism can be employed to assure long-term clout of the residual structure, the EMS Council or Committee? The federal funding effort provides capital funds for building some of the mechanical elements of the system - radio communication systems, for example. Those mechanical elements provide a service which most personalities within the system will see as desirable and necessary.

In essence, if the EMS Council or Committee is to serve as the long-range management entity, it must provide some form of commonly-needed and mutually-appreciated service. Consultation, advice and coordination won't suffice. People don't want consultation or advice. They don't want to be coordinated. They certainly don't want to be managed or controlled. Thus, if the long-range management entity is to be at all successful, it must possess some form of lure which will establish its position, validate its existence, and compensate for unpopular policy decisions it may formulate.

The Act was never intended to be a hardware giveaway program. Nonetheless, it is providing millions of dollars for hardware acquisition. That hardware is currently being dispensed by the grantees. That hardware can be committed to a regional service function that can serve as long-term glue for the system, that can provide the residual EMS Council or Committee
with substance beyond consultation and advice, and can lure all the personalities within the system into seeing that entity as the system's focal point.

An excellent example of this principle can be found in one of our midwestern states. There, a regional government organization has become an EMS focal point by designing and installing a regional communications system. It provides radio equipment to municipalities and service providers who are willing to accept certain policy prerogatives. The regional organization has never been overly popular with local governments in the region. But it has proven that old animosities can be quickly buried for the price of a free radio for an ambulance. The regional organization retains title to the equipment and thus can exercise the option of repossession in cases where regional system policy is not respected.

Two matters are important in analyzing this example. First, the regional government organization has not asserted itself as an EMS superagency - it is not a provider of direct services. Secondly, it has taken several years to achieve a status of recognition within its local political environment.

As EMS grantees, we should be challenging the contentions of the GAO report, but we should also be looking seriously to the future of those systems we are attempting to build. What will happen to them after our federal trough runs dry?

It is obvious that the GAO vision of a single management entity will not be satisfied in most areas of the nation. But it is also obvious that
we have a unique opportunity to use current federal resources to build a focal point for long-term management of a less ominous nature. We should set the stage for our EMS Councils and Committees to inherit the management role with a reasonable chance for success. As stated, that role must involve something more than just making the rules.

During the current year, our efforts have been largely directed to the needs of the critical patient, particularly that patient who must be transferred to a critical medical care facility. In the past, most such transfers have been poorly handled, if at all. Too often, critical patients are transferred for the wrong reasons to the wrong facility by people who have little capacity for critical care in vehicles designed for transporting the dead.

In reaction to this collection of EMS wrongs we should be building critical patient transfer systems. Through use of the federally-funded hardware, and a systems analysis approach to critical patient transfers, we should be creating a managed methodology for moving critical patients to appropriate facilities. And we should be placing long-term control of this useful and needed service in the entity which is likely to survive the end of federal funding - in most cases, the EMS Council or Committee.

We have found that physicians want a more intelligent method for transferring their critical patients to distant facilities. We have found that administrators are disturbed by the dangers in the current arrangements. We have found that ambulance personnel are aggrieved by their
lack of preparation and guidance in their role as transporters of critical patients. We have found EMS Councils and Committees wondering about their role at the end of project funding. This combination of doubts presents the opportunity to place long-term management of a needed system in an entity which needs visibility, identity and a meaningful task.

The GAO persistently views current grantees as regional management entities. It might be more appropriate to view them as regional EMS catalysts. These catalyzing agents can identify untouched service needs within their region. They can utilize federally-funded staff expertise and hardware in designing long-term systematic responses to those needs. They can design those systematic functions around long-term control by the residual EMS Councils and Committees. And in most cases, there will be satisfaction of the Congressional goal of improved emergency health care services.

The topic of this session is EMS legislation. We note that the GAO has met with Senate Subcommittee staff to discuss several possible changes in the legislation which they feel may help overcome the problems they allude to. That is a frightening revelation, given the GAO's demonstrated failure to understand the realities of community organization in general, and EMS in particular.

It is somewhat appropriate that this topic is under discussion at a Bicentennial Conference. This setting provides us with a reminder of those rebellious and cantankerous qualities which led to the formation of this nation. They are still out there - after 200 years. And they will not be dissolved by a sprinkling of federal money. They will not passively
allow the creation of EMS superagencies for regional management and control of their resources and efforts. And they will not be affected by any re-designed legislation which might seek to circumvent their independence.