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Committee on the Judiciary

D.C. Emergency Medical Service Commission

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POLICY POSITION: 2006 – 001

TITLE: ***ENHANCING MEDICAL DIRECTION OF EMERGENCY MEDICAL SERVICES***

DEFINITION: "Medical Direction" is defined as (i) physician-directed emergency medical care in which the EMS medical director assumes responsibility for the oversight of patient care administered by certified first responders, Emergency Medical Technicians or Paramedics who are providing medical care at the scene of an emergency or en route to a health care facility and (ii) indirect medical control including the written policies, procedures, and protocols for prehospital emergency medical care and transportation.

OVERVIEW: In order for an EMS system to function in a safe and effective manner, active participation by qualified physicians is crucial. The American College of Emergency Physicians Guidelines for Medical Direction of Prehospital EMS requires the designation of a physician as EMS medical director who assumes primary responsibility to ensure quality medical care throughout the system. Similar professional citations can be found from a variety of organizations including, but not limited to, the National Association of EMS Physicians, National Association of Emergency Medical Technicians and the National Registry of EMT's. Full authority is given to develop and enforce patient care policies & procedures as well as to provide valuable counsel and regularly evaluate system medical performance and training of members.

GOALS: Establish a medical direction organizational structure and sufficient resources to provide state-of the-art EMS.

Promulgate EMS treatment protocols and ensure they remain current. These treatment protocols must be evidence-based to the degree practicable and meet or exceed regional & national standards.

Develop and adopt clinically relevant performance indicators and benchmarks by which to monitor and improve system performance.

Measurably improve the quality of care through a robust and sustainable QA/QI program under the direction of the Medical Director.

Ensure that medical protocol is aggressively monitored and reviewed to prevent deviation from standards.

Meet or exceed the public's expectations for improvement and performance.

ORGANIZATIONAL STRUCTURE

A physician Medical Director should have control over all medical decision-making, and have adequate help and sufficient authority to assure quality care. This will require far more medical resources, personnel and information than are currently allocated.

The level of care of the EMS providers must be high and fully accountable. For this life-and death responsibility, treatment of EMS professionals should be on the same level as that of other public safety providers, namely Fire and Police.

To that end, there should be: A Medical Director with Associate and/or Assistant Medical Directors for each of the following areas:

1. Training and Education
2. Operations (medical equipment and medical supplies, provider safety, infection control, medical protocols, staffing)
3. Quality Management
    a. Quality Assurance (compliance with protocols, current operations)
    b. Quality Improvement (working for continuous, measurable quality improvement)
4. National Best Practices and Research (bringing in knowledge of evidence-based best practices in EMS, and contributing to knowledge in the field)
5. Disaster Management and Public Service Liaison (mass event and disaster planning, terrorism preparedness, regional and inter-jurisdictional issues, liaison with Fire, Police, mental health, etc.)

This role of the medical directors organizational structure does not ***address***, nor take a stand on the issue of EMS system configuration or what department(s) EMS should be integrated into (e.g. Fire Department, Health Department, Third Service, hybrids). The selection of an EMS system delivery model is a decision for the local community and its leaders. Each of these models has significant strengths and weaknesses. We believe that ultimately the success of an EMS system will depend on whether the jurisdiction has promulgated a system that 1) values the mission, 2) resources the operation and 3) respects the people who do the job. Selection and placement of a qualified Medical Director with the proper allocation of resources is consistent with these beliefs.

RESOURCES

Medical Director -

The EMS system requires strong medical direction. The Medical Director should be trained and board certified in Emergency Medicine, with a proven track record of both clinical competence and administrative ability. There also needs to be buy in and commitment from the Emergency Departments and Hospitals in the City with a goal of even and fair distribution of EMS resources amongst all hospitals as well as city clinics, Police, Mental Health, Dept. of Health and the surrounding jurisdictions. The delivery of prehospital EMS care is a component of a complex medical system that requires "open" collaboration across the spectrum to ensure competent and coherent coordination. Moreover, a Medical Director must have final authority over which providers are allowed to practice in the field. Decisions regarding EMS provider capabilities and competence specifically with respect to execution of medical skills must be under the jurisdictional authority of the system medical director. Failure to embrace and apply this vision places the individual medical director in a significant liability as well as the jurisdiction.

The EMS Medical Directors must be allowed to retain academic and clinical affiliations necessary to maintain clinical proficiency. Clinical practice by the Medical Director benefits the system by allowing the EMS Medical Directors to sustain their own high level acumen as well as interact with EMS providers in the clinical environment.

The EMS Medical Directors must be allocated the appropriate level of resources to effectively achieve their mandate. This statement should not be interpreted as giving the Medical Directors a blank check, nor does it imply uncontrolled or embarrassingly large expenditures. It does require an investment by the community to at least the industry standard including resources to recruit and retain medical directors' staff, equipping them and administering their activities to provide for continuous quality assurance of the EMS system. If rapid improvement is desired, then a temporary burst of extra resources will be needed. There are excellent EMS systems out there, and if the District expects performances at or near the "best practices" level, it will very likely have to fund the medical side of EMS at that level.

ACCOUNTABILITY

The Medical Director will be responsible for oversight of all aspects of the quality of medical care delivered by those who work under his/her authority.

EMS care requires a coherent collaborative team effort. Non-physicians are not as qualified or capable at determining the needs of and planning for medical intervention policies. Also, physicians cannot and certainly are not equally skilled in figuring out operational, personnel issues and recruitment and retention of skilled EMS providers etc.

Jurisdictional authority and prescribed actions for certain social issues should be reviewed to determine efficacy and appropriateness. The role of EMS in the evaluation of certain types of recurrent patients needs to be fully reassessed—for example, criminally dangerous patients where there may be a medical cause, treatment of public intoxicants and the homeless. Some aspects of these problems could be better-served and coordinated with social services and not the de facto safety net of EMS and the City's non-publicly funded community and university hospitals.

Clinical errors are inevitable in any health care setting. A recent study by the National Academy of Science estimated that as many as 98,000 people die in any given year from medical errors. (*That is more than die from motor vehicle accidents or breast cancer*). Given appropriate resources, the medical director of EMS should be accountable for responding appropriately to errors, monitoring the quality of care on a regular basis, and measurably improving it.

MEDICAL DIRECTOR AUTHORITY

The Medical Director should be responsible for the following EMS clinical areas:

- Quality management/quality assurance
- Training and evaluation
- Medical supplies need assessment and acquisition.

The Medical Director should have the authority and resources to recruit for and to hire for open positions in those areas he/she is directly responsible for, including having veto power over who fills the positions and the ability to combine or redefine the role of those positions, within DC human resources and other applicable rules and regulations. The staff assigned to those areas should report to the Medical Director or designee.

The Medical Director should report directly to the Chief of whichever agency is assigned the jurisdictional authority for EMS and have communications access to other branches of District Government as needed.

Assignment to staff positions in the training units and the QA (quality assurance) team should not be viewed as lifetime appointments, and those positions should be filled by the most qualified staff available, at the discretion of the Medical Director.

Budgetary Support

The Medical Director should have available industry standard resources to recruit and retain medical directors' staff, equipping them and administering their activities to provide for continuous quality assurance of the EMS system.

The Medical Director should have budgetary authority and be held accountable for the budget and staffing for those areas he/she is responsible for.

For effective operation, the new Assistant and Associate Medical Directors require contiguous, adequate office space, appropriate computer hardware and software, and support staff for their operations, including secretarial support and administrative assistants in each of the five areas, particularly during the start-up/catch-up phase. These assistants should be at the level of senior paramedic, RN, or other senior health care professionals in each of the five areas.

Sufficient fiscal resources must be invested to recruit qualified emergency physicians and others for the new positions, including:

- Money for advertising in professional journals and national newspapers (JEMS, Annals of Emergency Medicine, Academic Emergency Medicine, Wash. Post. Wash, Times. NY Times, etc.)

- Proper fiscal assignment to address costs of the recruitment effort (applicant processing, travel & logistical staff expenses)

- Compensation packages that are commensurate with the responsibility of the positions including: competitive levels of travel money, salary and benefits (50^{th} percentile for like-sized cities) for these positions.

- Grant money for EMS training, WMD preparedness and other priorities should be actively pursued, and the agency having jurisdiction for EMS along with the full community should assist and support that effort. For that purpose, a full-time grant writer should be employed to support the Medical Director in securing available funds from these arenas.

UPGRADE EMT AND PARAMEDIC TRAINING

Up-to-date standard certifications as specified by the Office of the Medical Director and consistent with prevailing policy, protocol and procedures are required of all EMT's and Paramedics with direct patient care responsibilities. No exceptions. There should be no use of formal or informal "extensions" that allow clinical care after cards have expired.

The department should provide full support for all federally (DOT) prescribed EMT and Paramedic training and recertification requirements.

Similarly, the department should provide full support for all DC Department of Health mandated training and recertification requirements, if any.

The department should provide full support for the training of all EMT's and Paramedics in the federally recommended curriculum for WMD recognition and initial patient care.

The Office of the Medical Director must be intimately involved with medical oversight for all aspects of training.

MISCELLANEOUS ISSUES

Response times - Although primarily an operational issue not under the direct responsibility of the Medical Director, ambulance response times clearly have medical implications. The following steps should be taken:

As recommended in the latest Inspector General report, all ambulances should have GPS navigation devices. (Radio Shack and similar vendors install high quality GPS systems for well under $1,000/vehicle.)

"Best Practices" systems will likely have helpful tips. We should pursue a one-time contract for a consultant from a "best practices" city to help us incorporate best practices and trim our response times to keep them in compliance with standards.

"Drop Times" - (time at the hospital when dropping off patients) are excessive and very problematical. Aggressive and innovative changes in current procedures are needed. For non-critical patients, if the hospitals continue to be unable to solve their delays at intake then consideration should be given to signing over EMS patients to a single team waiting in line in the Emergency Room and sending the other teams back into service. The hospitals themselves transfer such patient care from one team to another many times each day.

Academic Affiliation - Most of the top quality EMS systems across the USA have a strong academic affiliation with a university-based medical school. DC EMS would benefit from such an affiliation, and it should be pursued, including being able to offer an academic appointment at a medical school, which can be a cost-free but significant benefit in recruiting additional EMS physicians.

An Emergency Medicine Fellowship with two positions annually should be developed and funded. These programs enhance a system's stature, provide relatively low cost help, facilitate research, act as a pipeline for recruiting high quality physicians, and provide fresh blood and insight.

Adequate Number of Paramedics - Clearly, if there are not enough Paramedics, or the workforce is unhappy, then system quality will suffer. There are advantages to achieving and sustaining an optimal number of Paramedics within the system. It will take an aggressive, coordinated effort to recruit and retain them. Within six months the Chief and the Medical Director or their designees should assess staffing levels, determine how many Paramedics or

Basic EMT's should be hired, and analyze what resources (salary and other) are needed to recruit and retain them. These staffing needs are vital to the efficacy of EMS in the District of Columbia and must be fully funded.

Role of Paramedics and EMT's in the system - The work of EMS providers requires them to make life-or-death decisions in the field. For this life-or-death responsibility, treatment of all civilian (*single role*) EMS professionals must be on the same level and consistent with that of other public safety providers.

Additionally, apathy, complacency, indifference, and a poor work ethic cannot be tolerated by any EMS provider with hands-on patient care responsibility.

CONCLUSION:

Given these resources, the Medical Director should be able to accomplish the following three things during the first year:

- Measurably improve the quality of care provided.
- Intensify the level of physician medical supervision and training.
- Meet or exceed the public's expectations for improvement and performance.