EMS Research

Report on the First Regional EMS Forum

National Capitol Area

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REPORT ON THE FIRST REGIONAL EMS FORUM

Executive Summary

Background

On May 19, 2004, D.C. Fire & EMS hosted the first Regional EMS Forum. As leaders of frontline Emergency Medical Service provision in the National Capitol Region, Dr. Fernando Daniels III and Fire/EMS Chief Adrian Thompson of D.C. Fire & EMS recognized the need to achieve comprehensive regional coordination and emergency preparedness. They felt that a forum promoting balanced, open dialogue about regional EMS issues could establish a basis for future collaboration. In order to implement their vision, they approached the Center for Excellence in Municipal Management (CEMM) and the Institute for Crisis, Disaster, and Risk Management (ICDRM) at the George Washington University to further develop the concept, to conduct the forum, and to evaluate the feasibility of maintaining a collaborative network to address regional EMS challenges.

Goal

The goal of the Regional EMS Forum was to bring all EMS stakeholder groups to the table, a broader community than just Fire & EMS departments in Maryland, Virginia, and the District of Columbia, and to establish a vehicle for strengthening relationships and expanding regional cooperation to meet regional EMS challenges.

Participants and the Range of Institutions Represented

Participants represented the entire stakeholder spectrum, including policy makers, EMS system leaders, hospital and public health representatives, EMS educators, and field providers.

- 143 participants attended, representing 48 different groups or associations
- Geographical distribution of EMS-related organizations[1]:
  - Maryland - 8
  - Virginia - 12
  - District of Columbia - 13
  - Federal Government - 6
- Eleven counties were represented:
  - Fairfax County
  - Loudoun County
  - Prince William County
  - Alexandria County
  - Calvert County
  - The District of Columbia
  - Montgomery County
  - Prince Georges County
  - Charles County
  - Culpepper County
  - Howard County
- Private industry EMS organizations represented - 7
- Hospital/medical facilities represented – 8
- 8 Fire or EMS chiefs, 11 medical directors, and numerous Department of Defense hospital officials joined the discussions.

[1] EMS-related organizations are Fire/EMS Depts., Hospital Associations, MIEMSS, Northern Virginia EMS Council, Depts. of Health, EMA's, Governor's and Mayor's Offices of Homeland Security, professional associations, and others.

Academic Partners

The forum planners sought academic partners to assist with the project. Academic institutions with EMS interests were selected that modeled the geographic representation of the three "State" jurisdictions[2], including academics from Maryland, Virginia, and the District of Columbia. Their roles included content development, and facilitation of the forum breakout sessions and assisting in the development of the forum report. The partner institutions made a commitment to maintaining a balanced and open architecture for the forum, welcoming all concerned regional actors to provide constructive input.

THE GEORGE WASHINGTON UNIVERSITY, as the lead academic institution, was represented by two GWU entities:

- The mission of the ***CENTER FOR EXCELLENCE IN MUNICIPAL MANAGEMENT'S (CEMM)*** is to develop public leaders who make a positive difference in their organizations and the lives of the people they serve, by:
    1. Providing leadership and management development experiences which inspire public leaders and are grounded in research and practical knowledge, and
    2. Creating collaborative networks among public leaders to share resources, knowledge and experience.

- The mission of the ***INSTITUTE FOR CRISIS, DISASTER, AND RISK MANAGEMENT (ICDRM)*** is to improve the disaster, emergency, and crisis management plans, actions, and decisions of government, corporate, and not for profit organizations by transforming theory to practice. The Institute creates knowledge through its research activities and disseminates this knowledge through graduate education programs and training initiatives. The Institute's domain of interest includes natural and technological disasters, terrorism preparedness and consequence management, transportation safety and security, homeland security, and political/military/social/ and organizational crises.

THE UNIVERSITY OF MARYLAND BALTIMORE COUNTY (UMBC) EMERGENCY HEALTH SERVICES DEPARTMENT offers emergency health services graduate study that encompasses all EMS system components. The education program is primarily focused on preparing professionals for leadership roles requiring skill in planning, research development, and organizational operations. Staff researchers work on disaster medical and public health response, as well as the evaluation of timely EMS issues, such as the potential for paramedics to expand their scope of care. A major focus is medical response to disasters and terrorism.

THE NORTHERN VIRGINIA COMMUNITY COLLEGE EMERGENCY MEDICAL CENTER (NVCC) has long been recognized as a primary provider of health care profession education offering many EMS qualifications, such as an AAS Degree, EMT, and CCT certificates. The mission of NVCC is to meet the life-long learning needs of the Northern Virginia/Metropolitan region's healthcare workforce by providing a full service complement of programs for the acquisition of general skills, pre-employment training, customized education and training for credit and continuing education (CEU), professional development, and consumer health issues.

[2] For the purpose of emergency preparedness and Fire/EMS services, the District of Columbia is treated as a "State".

Meeting Summary

The EMS Regional Leaders Panel opened the forum, featuring recognized authorities at the forefront of EMS Service Delivery in Maryland, Virginia, and Washington D.C. Speakers were ***Fire/EMS Chief Adrian Thompson*** of DC Fire & EMS, ***Dr. Fernando Daniels III***, Medical Director of DC Fire & EMS, ***Deputy Chief Jay Brown*** of Loudoun County EMS and President of the Northern Virginia EMS Council, Executive Director ***Melinda Duncan*** of the Northern Virginia EMS Council and MIEMSS Executive Director ***Dr. Robert Bass***, who is also the Maryland State EMS Director. Each provided a brief but provocative view of current issues from their professional perspective, and a vision of how these issues may be addressed. A frank question and answer period provided audience input to this discussion.

Four afternoon breakout groups addressed the following topics of regional concern:

> ***Breakout #1*** **– Process: Building a collaborative network for this initiative and beyond**
> This session examined: impediments to any regional process focused at a provider level; processes and structures needed to support a formal regional networking process; and the role of COG and other official regional organizations.
>
> ***Breakout #2*** **– Common Inter-jurisdictional Issues**
> This session explored: Mutual Aid compacts (both strategic and tactical); response across jurisdictional borders; protocol coordination; and information sharing, both pre-incident, during large-scale events or crises.
>
> ***Breakout #3*** **–Operational issues faced individually by each EMS jurisdiction**
> This session discussed: Hospital/EMS interface difficulties; everyday EMS service delivery / everyday capacity; ALS versus BLS capabilities; EMS surge capacity and capability; and everyday communications.
>
> ***Breakout #4*** **– EMS personnel issues faced individually by each EMS jurisdiction**
> This session focused on the very difficult issues in EMS recruitment, training, and retention faced by every EMS jurisdiction in the National Capitol area.

Each breakout group discussed the current state of EMS efforts in their specific issue area and then crafted a set of recommendations to provide guidance for the next steps on which a collaborative network could concentrate. These findings present a compendium of regional EMS challenges as identified by participants, with their suggestions for changing specific aspects of current systems and devising models to establish a regional system with a higher level of performance. Another important product to come out of these breakout discussions was general consensus on significant EMS issues that currently compromise optimal readiness for response to a mass casualty terrorism event in the National Capitol area.

Major Findings

The Regional EMS forum project was designed to evaluate methods of addressing regional EMS issues in the National Capitol area. It provided a forum to promote balanced and open discussion of common jurisdictional EMS problems faced by individual EMS providers, and inter-jurisdictional issues spanning the full range of EMS stakeholders from the National Capitol area. The large turnout represented the geographic and organizational spectrum in the region, and the level of enthusiastic participation indicated an endorsement for both the forum process and forum content.

By answering the question, "***Where do we want to go with inter-jurisdictional collaboration in EMS?***", participants in Breakout Group #1 were able to reach consensus that their goal is to foster inter-governmental relationships that would result in a better understanding of neighboring jurisdictions, better coordination, and a way to collectively confront regional challenges. Members of all breakout groups expressed wide support for establishing a collaborative network that identifies significant issues and continues the discussion among representatives across the National Capitol area. They also endorsed the forum format that encouraged participation by field providers and the full range of EMS stakeholders, as well as Fire/EMS leadership. This format generates ideas from the point of view of localities and EMS providers / responders within local jurisdictions, provides an opportunity for wide discussion of the ideas, and allows vetted ideas to "flow upwards" to the highest political and administrative levels, influencing policy debates and system improvements.

Other important issues identified during these discussion included:

1. Increased ***collaboration***, less turf protection, and building relationships beyond the scope of the usual government responders are critically important.

    - There is great difficulty in bringing all three levels of government (local, State, and Federal) and the breadth of EMS stakeholders together in any formal government forum such as MWCOG[3].
    - Members of the private sector and volunteers have no official voice at MWCOG forums.
    - Fire/EMS and public health collaboration is still in a fledgling phase of its development.
    - Many newly recognized partners (including public health and hospital alliances) need to become part of ***regional EMS information and communication networking***.

2. Current inadequacies in inter-jurisdictional EMS collaboration translates into ***sub-optimal EMS Homeland Security capability,*** threatening effective response in a mass casualty event. Effective mass casualty preparedness should begin by improving the delivery of everyday services.

3. There is a lack of definition and certainty about ***roles and responsibilities*** surrounding EMS crisis events, as well as a lack of operational knowledge about inter-jurisdictional contingency plans, unified command operations, and emergency response within the EMS community.

4. Day-to-day ***surge capacity and hospital overcrowding***, as well as weak ***hospital-EMS interface,*** are threats to preparedness goals that have been set by State and Federal initiatives.

5. Problems with day-to-day ***information-sharing*** are pervasive and are exacerbated by duplication of efforts in terms of OC's and communication systems that hinder inter-jurisdictional communication and integration.

6. States and the region have not yet developed ***adequate*** and ***consistent*** strategic EMS ***mutual aid*** instruments.

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[3] Metropolitan Washington Council of Governments (MWCOG) has representatives from governments in the formal National Capital Region, which does not include all jurisdictions in the current National Capitol area. The forum participation was inclusive of this larger geographic area.

7. Jurisdictions across the National Capitol area face a lack of qualified EMS personnel, causing an overburdening of current EMS providers and managers. This in turn causes "burnout" and further loss of qualified personnel. ***Recruitment, training, and retention*** issues are impacted by the variation between EMS systems in the region. There is an inadequate focus on improving EMS providers' skills, education, and assessment tools and a sense that a career in EMS can become a dead end job, with no chance for advancement and self improvement.

Discussions in each breakout group moved beyond a problem focus to lively presentation of new ideas to address the identified issues. The following concepts were produced by forum participants:

1. Conduct ***academic and operational studies*** to investigate system-enhancing ***innovations*** and "***best practices***" in training, exercises, EMS personnel retention and other areas. Promising products could be prepared and presented to the appropriate EMS-related communities of practice.

2. ***Networking and information-sharing*** across the region can be fostered by a continued dialogue in future forums.

3. ***Standardizing the coordination mechanisms between jurisdictions,*** rather than trying to make all intra-jurisdictional systems identical, may overcome the many years of failure with the latter approach. Participants expressed a strong interest in this approach, which focuses on standardizing how EMS and medical organization integrate during response. . Guidelines to establish this could be incorporated into strategic mutual aid instruments, regulations developed for the Emergency Management Assistance Compacts, and other formal mechanisms.

4. Regional information systems that are currently under development in public safety initiatives (such as the fire resource manuals) could be used to ***"tag" EMS issues***.

5. ***Understanding*** of the ***challenges*** in the regional EMS environment ***must increase***, including policies, guidelines, legislation, protocols, mutual aid compacts, roles and responsibilities, and jurisdictional structures and processes.

6. The implementation of enhanced ***inter-jurisdictional coordination for day-to-day responses*** would provide immediate benefit to the public, while enhancing EMS operations in crisis response scenarios.

7. An ideal time to ***practice response relationships*** is ***during the many planned mass-gathering*** events in the National Capitol area, particularly since these could become mass casualty incidents. The presidential inaugurations, 4th of July on the Mall, the WWII Memorial event, were pointed out as ideal opportunities to bring organizations together and train/exercise toward improved coordination.

The Way Forward

This project offered an innovative platform where regional ideas could be presented and openly discussed in a balanced fashion. Many of the ideas developed during the one-day meeting warrant

further discussion and analysis. Participants as a group endorsed the concept of an ongoing EMS forum series, retaining the content areas and forum format piloted during the May 19, 2004 meeting.

The consensus of the forum planners and session facilitators is that the forum met its goal: demonstrating that this interactive approach can effectively bring together EMS stakeholders from across the National Capitol area to address critically important EMS issues. Their analysis suggests that a forum series may be shaped to develop consensus products that can become operationalized through new policy, systems and procedures implemented across the region's jurisdictions. The forum planners therefore recommend that this initiative continue, subject to available funding that can provide the necessary financial support.

Future forum sessions will be designed to focus upon specific issues and potential solutions identified during the May 19, 2004 forum. "Discussion papers" developed by the forum academics prior to each session will present the issues for the specific forum, with associated background information and initial recommendations, potential alternatives, and secondary implications identified during the May 19, 2004 meeting or defined through further research. Additional ideas will be sought during the forum discussions; recommendations will be altered or refined; and consensus will be sought. Follow-on activity will capture the thoughts expressed during the forum discussion, and evolve the "discussion paper" to a detailed issue paper with operational recommendations. The paper will be circulated among participants for final input and any major objections, and will then be finalized.

Policy prescriptions and formal recommendations can therefore be thoroughly vetted by regional stakeholders, alternatives can be researched, and optimal EMS solutions developed. These *policy and practice recommendations* can then be presented to authorities in each jurisdiction who are responsible for policy, strategy, and tactical oversight of response systems, and for training and education of EMS and related disciplines. Forum participants involved in the consensus products can become forceful advocates in their home jurisdictions, increasing the likelihood that the recommendations will receive serious consideration by appropriate authorities.

Breakout #1: Building a Collaborative Network

This breakout group was tasked with a very complex set of deliberations. The concept underlying this regional EMS Forum was to explore and possibly develop a foundation for a collaborative network; one that could identify challenges and make policy recommendations to improve EMS service delivery across the National Capitol Area. Currently, many regional EMS policies and procedures are developed, debated and accepted at the highest political and administrative levels, and then flow down toward state and local providers. A collaborative network would set up feedback loops to strengthen horizontal communications and generate ideas from the point of view of localities and EMS providers/responders within those jurisdictions. The task of this breakout group was to look at collaborative networks and how they might work in the future. Some of the immediate questions considered were: What is occurring now with EMS inter-jurisdictional collaboration? Where are we going? Where do we want to go?

Since coordination and collaboration are major goals that are intended to bring about EMS improvements and enhance our collective ability to respond to regional needs, a clear definition of what is meant by coordination and collaboration is needed. A time dimension to collaboration (past/present/future) must be considered if the capacity for interaction amongst multiple parties is going to be developed. The Department of Homeland Security (DHS) maintains that coordination and collaboration mean domain awareness or situational awareness. Achieving a clear definition of what these terms mean for EMS providers may help to delineate clearly what the focus of a collaborative network would have to be.

The State of Current EMS Inter-jurisdictional Collaboration

Coordination in the public health, medical and EMS arenas is less robust than in other public safety areas. Group participants conjectured that this might be because we haven't had a public health emergency along the lines of 9/11. While 9/11 was a mass fatality incident, it didn't result in a major mass casualty/mass injury event with a large number of treatable injuries. Thus, our EMS and medical systems weren't fully tested. Public health and EMS were not really challenged.

Collaboration surrounding public health emergencies represents the ability to seamlessly integrate regional efforts in five essential categories: command, communication, protocols, people, and EMS/hospital interfaces. Great weaknesses currently exist in all of these five areas, but some progress has been made. Amongst the platforms and types of inter-jurisdictional collaboration that are taking place now, there is a central DHHS web-site that provides daily information from the CDC, federal government agencies, etc. First responders have much stronger bonds since 9/11 and informal and formal communication occurs concerning threats/issues, etc. This communication allows actors to respond to the current threat environment. There is an attempt to mold current practice to fit the next, new threat. There are many new partners to new communication efforts, including people that traditional first responders have never worked with before. The anthrax incident made this very clear: Public health officials appeared overwhelmed by their new role and interactions with FBI,

police, and the entire array of EMS stakeholders. The relationships that were essential to properly working that crisis scenario were non-existent and must be created now.

There have been recent improvements in the role of D.C.'s Health Department with regards to urgent public health information. They have set up an agreement with DHHS to deal with future situations jointly. There is also more sharing of health data and more collaboration in the public health system. But within Fire/EMS departments, there is less consistent data collection and little data sharing. Enhanced collaboration requires the break down of old mind sets about protecting turf and data and proprietary information systems. Fire/EMS has more of a culture of "turf" protection than the public health entities with whom they must work.

Participants felt that in regards to EMS issues, they know a lot about what is going on in their own counties, but could use more information about what is going on in the rest of the region. A Montgomery County participant, for example, stated that Montgomery County Fire/EMS is working hard to establish and increase their collaboration with public health agencies, because it sees these relationships as crucial to improved future performance. Participants felt this was a very important area to concentrate on and wanted to know what the links between Fire/EMS and public health are in D.C., Virginia, and Maryland, which indicated that an overarching understanding of collaboration between these important parties is currently lacking. Representatives of other jurisdictions were hard-pressed to provide any information about the state of this type of collaborative effort. It became clear that Fire/EMS and public health collaboration is in a fledgling phase of its development and much needs to be done in this area.

Participants expressed how difficult it is to bring the different levels of government together. They maintained that this is not just a monetary issue, but that organizational culture and funding competition inherent to the governmental system create barriers and prevent collaboration from moving ahead quickly. It was pointed out that the mindset of the actors who are involved in these efforts is often inimical to the very goal that they are actively pursuing. An example of this within Homeland Security efforts is that Federal government parties like to keep things secret. It was further suggested that organizational/jurisdictional interests often get in the way of collaboration. Other identified obstacles included politics; complexity; not knowing who is in charge; a lack of definition of roles and responsibilities of the various actors that make up regional efforts. A great deal of confusion about 'who is in charge' was expressed. Participants weren't sure if it is D.C. or State government, the "Feds" including the CDC, DoD, the Marines, or the DHS. The complexity of the National Capitol area, in which there is a great deal of institutional fragmentation, was pointed to as a primary cause of this confusion. There is no lead "agency", a fact that creates obstacles to collaboration. Since D.C., the counties, the States, and the Federal government are all located within the region, there is uncertainty about organizational responsibilities and authorities. This is demonstrated by the fact that D.C., Maryland and Virginia all have different EMS protocols. There was also the complaint that the federal government deals with the "states" including D.C., but not with the local jurisdictions and the region as a whole. On the federal level, while there is some lip service

about the need to work on a regional level, there are no visible attempts to work in a fashion that would promote such a goal.

Examples of attempts at regional collaboration are instructive. Recently, a committee at MWCOG monitored the West Nile Virus situation. Committee members tried to collect data from the region on WNV incident, which turned out to be very hard to accomplish. The effort was fragmented and not connected to other data collection activities. The data itself couldn't be collected in a timely fashion. Another example comes from similar efforts at collaboration and data collection that went on during the "brown heroin" epidemic that affected the East Coast about 10 years ago. The 2001 anthrax incident was also a case study in failed collaboration thanks in part to confusion about who was in charge. In the end, the D.C. Hospital Association provided a center for collaboration regarding day-to-day issues. The ricin case on Capitol Hill again served to highlight these very same issues two years later.

Metropolitan Washington Council of Governments - COG

The MWCOG and their regional response plan is the basis for information exchanges and regional coordination in the National Capitol Area. COG is the area's only regional forum for collaboration. It represents a neutral space where government actors from all across the region can come together and work on regional challenges. There are both positive and negative aspects about the current COG structure. COG is an excellent platform for regional policy discussions and a starting point for building relationships, working on joint projects, unifying protocols, etc., but it is not an organization that has the ability to create new operating systems. The region lacks a central place where it can operationalize regional ideas. That is an area where COG cannot bring about implementation and operational progress. In addition, current homeland security funding streams are not enhancing COG as a regional vehicle for collaboration, and although COG has been tasked severely since 9/11, much more support needs to be provided to this venue. Participants felt that we need to build on what we have, instead of creating something new. This means strengthening COG and not replacing it. COG also needs to expand to cover all counties in the National Capitol area.

Chief Thomas Carr of Montgomery County and the Head of the COG Fire Chiefs committee spoke about the collaborative value that COG has added to the region. He stated that the COG Fire Chiefs meeting is the best resource for regional relationships. There is no more powerful resource than what COG offers. The Fire Chiefs meet once a month with chiefs from 19 counties in attendance. They also have conference calls every two weeks. There is a very high level of participation because people value the forum. Those working together through COG have finally understood that what is good for the region is good for our organizations; and what is good for our organizations is good for the region. Fire/EMS organizations have committed resources and time to the COG committees because they value the relationships and what they get out of the COG process. Those relationships have grown exponentially since 9/11. There has also been a tremendous growth in the power of the Fire Chiefs Committee. The committees have been able to have $33 million in UASI funding designated to projects they actively campaigned for. The reason why this was possible was

due to the powerful relationships that were formed. Many voices in support of "one message" means regional actors are indeed able to influence federal policy. Chief Carr also emphasized that the EMS forum here today is a result of the COG mechanism. The original concept came from within the COG Fire Chiefs venue.

Information Issues

The discussion about regional information flows unveiled a tremendous amount of duplication of efforts in terms of gathering information. There are several surveillance systems that exist in the region (COG/FRED/DHHS). D.C. recently signed up to be a part of FRED, which participants felt has greatly benefited regional collaboration. The status of the participation of other regional partners in this effort is not clear, thus there is a sense that the information gathered at these central points is not being disseminated well or in a consistent fashion. MWCOG's RICCS system is supposed to provide a central communication function, but there are many other agencies vying to be the central point of different forms of information. DHHS has a "war room" that can call up large amounts of information, but who is privy to this information is uncertain. Recently, a syndromic information system for the region was established at the Johns Hopkins University. These initiatives stand to offer some enhancements, but there is still a need for a system that interconnects everyone with the information that they need when they need it. EMS communication systems across the region are not effective. Participants felt the need for one central agency that provides day-to-day information across the region, not just for emergencies. Participants expressed that no one seems to be driving the regional ship when it comes to communication. There is no regional data system for collecting information about reportable diseases. Some participants expressed frustration about the fact that attempts to get a regional system established have been going on for some time and have not yet borne fruit. Participants agreed that guarding against information overload needed to become a priority very quickly. Efforts need to be focused and not just gather information for information's sake. Another priority was to start to deal with duplication issues and to learn how to better structure and disseminate information.

Where We Want to Go with our Collaborative Efforts?

Participants felt that there is a need to talk about collaboration for the future. The future is not just going to deal with bigger events, it is going to deal with very different events. We need to be careful to not just design for the last disaster incident. Big events "aren't just large-size little events," meaning planning cannot look at the future in this manner. What the EMS community currently knows how to do is to "haul casualties to the hospital, one at a time." What if more is needed? There was discussion about what the tasks of the future will be, what the EMS community is going to be called to do. Collaboration looks as if it will need to involve everything from information sharing to analysis and after-action reviews. After action reports, such as the one for Hurricane Isabel for DC government, show us how many of our systems are pushed to their limit in an event and can help us make necessary changes.

One of the primary goals that participants identified for a collaborative network was to create a vehicle to input local views into the policy-making apparatus. Resonance was expressed for the idea that the EMS environment is being discussed "at the top" without enough involvement of local actors. There was also some discussion about the shortfalls of the National Incident Command System, which is not yet operational across all functions, including safety and public health. Participants felt that this area of policy should be looked at within the context of an influential collaborative network.

Another set of questions that were entertained were "What are the elements of the network we might want to create?" and "What improvements over the current system would it have to offer?" Networks should contain nodes and connections among the nodes, and a network description should address these and other critical elements of the network that manage timely information. There needs to be a formal information/communication infrastructure component. Information needs to flow between the nodes. Collaborative networks aren't just about data either. Collaboration depends upon people and relationships. It took a lot of effort just to get mental health professionals involved in Homeland Security and EMS planning. We have to continue working on knowing the players, building the relationships, and expanding the network of those who will be crucial to effective response and recovery. The way to get things done is to get to know the actors.

Building relationships cannot stop with the usual government responders. We are facing a very new EMS threat environment, and must mold current practice to address these new threats. "We have a lot of new partners, people we never worked with before. The anthrax incident really made us see this. We had to … work with public health, and oh—surprise—public works." Non-governmental actors (hospitals, medical practitioners, laboratories, environmental testing and clean-up companies) also had to be integrated into the response.

We must develop relationships within and between our communities, if we are going to be effective. The continuum for safe communities needs to start with improving the everyday 9-1-1 call, and extend through to planning for major events and all the way out to recovery. Networking and communications are also essential for protecting the well-being of the responder community. Not only the public, but civil servants and responders themselves must feel that their personal safety and that of their family is secure, when facing major events. The fundamental responsibility of EMS leadership is caring for and supporting their people and networks offer us the possibility of hearing their concerns and responding appropriately.

Breakout Group #2: Common Inter-Jurisdictional Issues

The participants in this group discussed common inter-jurisdictional issues as they relate to day-to-day operational concerns as well as mass casualty incidents.

EMS Management Coordination, Preparedness and Response

Key concepts that were discussed included:

- Coordinating EMS management between jurisdictions, rather than expecting a single jurisdiction to "command" others; participants expressed a sense that this can be accomplished with an effective preparedness effort and effective incident management processes during an event
- Revising the authority question from "Who is in charge?" to "Who is responsible?" may provide for a more constructive dialogue and a better approach to determining who has the lead on specific issues/tasks/processes. By maintaining good information sharing systems, multiple responsibilities can then be coordinated
- A focus upon standardizing the coordination mechanisms *between* jurisdictions rather than trying to make all intra-jurisdictional systems identical, may overcome the many years of failure with the latter approach.

Mutual Aid Compacts vs. Agreements

A question posed to the group was: "How do we develop strategic mutual aid pacts between states, so that we can develop tactical mutual aid pacts in the jurisdictions?"

There was consensus that states and regional jurisdictions need to develop adequate and consistent strategic EMS mutual aid instruments across the National Capitol Region. Strategic agreements provide the guidance for regional EMS stakeholders to develop or revise tactical mutual aid pacts between their organizations. The tactical pacts address day-to-day sharing of EMS resources in contiguous areas, as well as the multiplicity of EMS providers that would be called upon to respond to an incident. They guide the coordination of small-scale actions and also provide a consistent, valid structure and process for obtaining and coordinating assistance during large-scale or unusual events, while retaining capabilities and procedures that reflect local realities.

The Emergency Management Assistance Compact (EMAC) was identified as a legitimate vehicle that could be used to establish strategic agreements for EMS assistance across State boundaries. Concern was expressed that while EMAC has been ratified in Virginia, Maryland, D.C. and most other "State" jurisdictions, EMS and other medical/public health care resources have not been adequately addressed in the compacts and related regulations/legislation/processes.

Critical aspects of EMS mutual aid integration between jurisdictions were defined and discussed. These include:

What are the rules of engagement for people who are being pulled in and how do they get communicated? Mutual aid may most effectively be used in some situations to backfill the jurisdictional areas where units have been "pulled" to an incident scene. The mutual aid instrument must stipulate that some jurisdiction personnel are assigned to manage this backfill, which is provided by mutual aid resources with tactical guidance from jurisdiction personnel. This allows the locals to address the complex incident scene, while everyday jurisdiction responsibilities are still covered.

"Mutual aid" means providing assistance without expecting reimbursement from the assisted jurisdiction. This has a long public safety tradition, but does not provide a qualified charge to submit for State or Federal reimbursement. California provides the example of replacing "mutual aid" with "cooperative agreements," which define when and how expense charges become effective during a response. This allows mutual aid for small, routine actions, but captures and addresses costs in the larger and/or sustained responses.

"What are the 'rules of engagement' for resources that are being pulled in and how do they get communicated?" Representatives of federal EMS resources brought up their responsibility for providing back up or supplemental service to local responders. They expressed frustration that their capabilities were being underutilized and described their dismay at not being put to work when they responded to the 9/11 Pentagon incident. A discussion ensued as to how to address this issue and so make effective use of these potentially valuable resources. A major barrier to implementing the capacities of these units was identified: that they have no relationships to local actors. It was also recognized that these responding units must understand they may not be used according to their expectations. Assigning a local responder to these resources could help facilitate their being rapidly integrated into a response, and coordinate their activities on-site.

Knowing what resources may be available, and operationally important information about them, was identified as a major issue. Within the context of establishing the strategic mutual aid framework, EMS resources from all participating jurisdictions can be catalogued and their information distributed. EMS officers across the National Capital area can become aware of available resources and their capabilities, limitations and support needs during the preparedness phase of emergency management, rather than under the stress of response. Developing a standardized template for a resource Fact Sheet will provide clear information on each available resource, and can also be used during an incident in briefings, in incident planning, and in evaluating performance.

Protocol Coordination

The discussion focused on standardizing EMS and other medical protocols in the NCR. Some expressed that there needed to be universal guidelines to dictate what was going

to be done and what would be allowed when personnel respond to another jurisdiction to practice.

It was agreed that the NCR region has had extensive experience with attempting standardization in the last 30 years. The difficulty of standardizing protocols and procedures across multiple jurisdictions was recognized, particularly when the everyday EMS needs and priorities of each jurisdiction differ. Another major issue expressed is that no adequate funding to standardize protocols or equipment is available. Private sector partners to EMS were particularly concerned about this fact: ambulance company representatives stated that they have seen no monies coming in to support their preparedness, including training and equipment purchases.

Participants expressed an interest in changing the approach to this standardization issue by focusing instead upon standardizing how EMS and medical organization integrate during response, rather than on internal standardizations. Guidelines for this could be incorporated into the strategic mutual aid instruments.

Regional Management Coordination

The above topics led directly into a discussion about the rules of engagement for a unified command scenario and how these rules get communicated. Confusion was expressed about the state of planning for immediate response needs, indicating that whether or not such plans were in existence, their contents are generally unfamiliar to the EMS responder community. This lack of operational knowledge about inter-jurisdictional contingency plans, roles, responsibilities, unified command operations, and emergency response was a concern expressed by many across the EMS community. In terms of the expandability of everyday response operations, the need for basic response equipment for those coming in and its availability was paramount to this group. There was agreement that different responding groups will not have the same equipment. At COG effort is underway to set up equipment catalogs for mass casualty situations, (for example: a standard a list of equipment that a level 1,2, & 3 unit has is being catalogued), but reservations were expressed that this may not be a successful approach.

Agreement was expressed that information sharing was critical to management coordination, and extensive discussion of issues related to information ensued.

Information-sharing Pre-incident

Mass casualty incidents and unified command responses involving many jurisdictions and levels of government are extremely complex due to the number of potential responding entities in the National Capitol area.

How might we better develop and formalize day-to-day information sharing processes, so that we know what is going on in each jurisdiction? Multiple simultaneous

incidents in separate locations would also pose a significant problem. How can information be funneled to responders while they are underway to an incident? We are dependent on the radio infrastructure in our local jurisdictions, but they do not commonly reach beyond our own jurisdictional borders, and we have to be able to use other local jurisdictional channels to communicate with one another.

It was expressed that unless we start to institute better information-sharing procedures on a day-to-day basis, we will encounter major problems in a disaster scenario. The day-to-day implementation of capabilities primarily intended for mass casualties should also solve the many problems that are pervasive in EMS service delivery. Participants expressed the feeling that the information processing and communications integration should be effective everyday, not just for unusual events.

The capabilities of current or impending communications systems, such as the RICCS and CAPWIN, were discussed in relation to the EMS community. Some expressed the concern that as these communication systems proliferate, many emergency managers feel they are connected to too many of these systems and that their "Blackberries are going off all the time." A recommendation was offered that a web-based interface would be superb for getting information down to the street level responders. Often information about training and what upper level managers are planning to do is not trickling down, and it needs to.

The issue of coordinating and integrating the many current data collecting systems was discussed. A consensus emerged that the processes, definitions, analyses, and information distribution must be standardized and coordinated better or we are underutilizing these valuable information sources.

Questions about the role of the Department of Homeland Security were raised. What is the DHS's regional coordinator doing for this field (EMS coordination)? No one was able to offer an answer to this question, as well as to answer what DHS-level expectations are in terms of EMS responses. It was equally clear that the group was not able to crystallize their expectations of DHS. This lack of definition of the DHS role within the region was disconcerting to many group members.

Event- and Crisis-specific Operational Information-sharing

Many of the issues stated above carry over to an incident or crisis and if well implemented on a daily basis will aid crisis response efforts. Incident notification, for example, should be through the communications means used everyday across the regions EMS-related organizations.

If an EMS response unit is arriving at an incident scene and must be briefed on pertinent information before taking action, a significant delay may occur. Conversely, acting without understanding the response circumstances may be detrimental and dangerous. What can be accomplished to expedite this before assisting parties arrive at a disaster or emergency scene?

It was noted by one participant that WMD training has presented what we are to expect in terms of ICS in major incidents and how it will be expanded, but how responding personnel will understand what is going on is still unclear. Whatever certainty there may be at higher levels, within this group of quite prominent EMS stakeholders there was confusion about how information and resources would be shared and how communication about them would take place. The need for a more defined and disseminated model of this cross-jurisdictional incident management was clearly indicated.

Critical Incidents

EMS providers pride themselves on rapidly responding and transporting patients from the scene to appropriate medical destinations, and yet in critical incident scenarios, this task is prolonged and much more complex. Also, the transition from first responder emergency medical care to providing the on-going medical support for scene responders means transforming operations to both a preventive medicine as well as a "treat and transport" capability. Training for the transition, including setting up operations and managing the medical support mission, must be better developed. Participants expressed that little guidance is available to the general EMS community about how these transitions occur, and how to train for the additional missions.

EMS practitioners, as with all public safety responders, work in a culture that emphasizes "taking care of their own." Questions were raised about how to ensure that type of care is effectively performed in a major or unusual incident. What are the guidelines and training for this and do the hospitals understand this priority?

From Ideas to Implementation

How do we move all the things we are talking about forward beyond discussion into implementation? What are the ways we can offer some final products and policy options to the COG Fire Chief's Committee and other venues? How do we define regional EMS systems so that it is easier to train people? These questions became the focus of the closure point for the common inter-jurisdictional issues breakout group. Of the many challenges and recommendations that the group generated, there was a feeling that these issues were very real and the discussion should be "more than hot air." Earlier in the session, participants expressed a concern that frontline providers must be included in the plans for EMS preparedness and response. If people drawing up the plans have never "walked the walk," they may miss "little things" that could be catastrophic. The current very slow rate of change/improvement was also cited as a major concern by participants.

The implementation process for future recommendations became the focus of the final portion of the session. Continuing a regional EMS forum such as this, and developing recommended improvements that could be presented to local, State and regional authorities for considerations, was supported.

Participants stated that it was important to recognize that the time to practice response relationships is during planned mass gathering events that could become a major incident. The presidential inaugurations, 4th of July on the Mall, the WWII Memorial event, these were pointed out as ideal opportunities to bring organizations together and train/exercise toward improved coordination. Processes that promote coordinated local improvements and a "bottom-up" approach was suggested in terms of implementation, since it fits well with the mantra that "all response is local." It was expressed that instead of waiting for Federal entities in the area to get up and running and set expectations, the localities needed to band together and set up solutions that matched their realities. Major planned events could be used to integrate these local system improvements.

The group reporter focused upon the following implementation issues as the most critical to address:

- Implementing the inter-jurisdictional coordination into day-to-day use
- Using the regional information systems that are currently under development (such as the fire resource manuals) to "tag" EMS issues also
- Standardizing the interface between EMS jurisdictions as a priority

Breakout # 3: Operational Issues in each EMS Jurisdiction

The group discussion began with each participant introducing him/herself and describing the one EMS-related problem that they felt affected them the most. Participants then responded to one another and brainstormed about what they felt were the most important problems facing the National Capitol area EMS community as a whole. These were later narrowed down to four major topics: Communication issues, information management, personnel, and hospitals; and two secondary issues: Role Definition and EMS-Homeland Security Interaction. The latter two were later expanded upon and formed important categories of discussion, despite being difficult to define and isolate.

Since this breakout group contained a large number of field level EMS responders, the most prevalent complaint was hospital overcrowding (an inability to handle everyday surge capacity) and its effect on the EMS-hospital interface. While hospital overcrowding is a problem that is larger than, and extends beyond, the EMS-hospital interface (see below under "Health Care System Interplay"), EMS difficulties were attributed to a lack of effective communication. The most frequent complaint involved a communication problem between hospital EDs and ambulance units (both public and private). Often EMS units arrive at a hospital only to find it overcrowded and are then forced to transport their patients elsewhere. Further complicating matters is the fact that EMS units were often at odds with hospital staff. Both EMS practitioners, as well as the sole civilian nurse attending the session, spoke at great lengths about how each group viewed the other in an "Us" versus "Them" manner, and both sides felt that the other group was not sensitive to their situation. The attendees also identified communication problems between EMS providers and 9-1-1 dispatchers as a significant issue in this problem area. Oftentimes, EMS practitioners felt that the dispatchers were unable to accurately convey hospital status information.

The participants noted that although intra- and inter-jurisdictional communication was better than before (as a result of the events of 9/11), it was not yet integrated well enough to be effective. They felt that on an inter-jurisdictional level, first responders and hospital staff did not know enough about each other's roles to utilize each other effectively. They believed that since each group was unaware of the other's skills and limitations, they would often base their interaction on assumptions that weren't grounded in reality. As a result, first responders often felt that other organizations weren't as helpful as they could be.

Although participants admitted it is improbable that all the jurisdictions within the National Capitol area will ever standardize their procedures, much less their equipment, they felt that inter-jurisdictional communication and cooperation were highly limited due to this fact. Participants identified the main reason for this inhibited cooperation as a problem with information management. They noted that there was a lack of standardized data definitions, as well as a lack of standardized data collection techniques. As a result, it is difficult to compare EMS data between jurisdictions. For example, some jurisdictions define response time as the time between when a patient dials 9-1-1 to when the ambulance unit arrives at the patient's address. Other jurisdictions define response time as the time between when an EMS unit receives a dispatch to when it arrives at the patient's side. Another example is how various jurisdictions define successful cardiac resuscitation. One jurisdiction may define it as

reviving a patient's heart on the scene, and having that patient survive his/her ordeal through to hospital discharge. Other jurisdictions define successful heart resuscitation as reviving a patient's heart on the scene and delivering that patient to a hospital with his/her heart still beating. The final outcome for that patient is not factored into the process.

With such important differences in basic definitions, it becomes difficult for jurisdictions to measure and compare performance and best practices. As a result, funds may not be available or may be distributed improperly. More importantly, lack of agreement on definitions contributes to an inability of EMS providers to work effectively with each other during crisis situations.

The EMS participants noted that another major problem with information management is the lack of feedback from the data they record. While some jurisdictions (i.e. Richmond, VA) furnish EMS providers with detailed feedback in order to help them improve, most EMS personnel have no idea where this information goes to or how they could possibly access it.

Personnel issues were important to the attendees as well. Simply put, there are not enough EMS providers to furnish adequate coverage for this region. This leads to the overburdening of current EMS personnel, subsequent burnout, and loss of qualified personnel as experienced providers leave the EMS field. This exacerbates the situation, and fuels a growing inadequacy of qualified EMS workers in the region. Since this is directly related to funding, the cycle will continue until an adequate number of EMS providers are budgeted into each jurisdiction's system.

Participants also noted that there is an inadequate focus on improving EMS providers' skills, education, and assessment tools. Many expressed the sense that this creates the feeling that a career in EMS can become a dead end job, with no chance for advancement and self-improvement.

Many participants conveyed that they weren't getting enough of the right kind of supervision, with too many bosses and each with his or her own vision. Field providers felt that unless their superiors had EMS experience, and could do their job if needed, they were an ineffective source of oversight since they didn't fully understand everything that the provider is up against. This poses a significant problem, because, as one participant noted, most of the administrative staff had no such experience. This may be a particularly acute problem in fire department-based EMS systems, in which fire officials who lack any personal EMS experience or training supervise EMS personnel.

Health Care System Interplay

While hospital overcrowding was the biggest everyday concern facing EMS providers, the breakout group came to the conclusion that the overcrowding issue cannot be solved locally because it is a symptom of the American health care system's inadequacies. Until adequate health insurance is offered to everyone, many of society's poorer individuals

will use the ED as their primary service point in the health system. Furthermore, as hospitals struggle to act more like businesses, they find themselves at odds with the goals of emergency preparedness. Hospitals, like any competitive business, cannot maintain expensive excess capability without an external funding source. As a result, when a surge capacity is needed, hospitals continually find themselves understaffed and overwhelmed.

Roles and Capabilities

Participants expressed a sense that public knowledge about EMS is lacking. While the public knows when to call the police or firefighters, they often utilize EMS unnecessarily because they do not fully understand this service. This backlogs the entire system. The participants felt that greater dissemination of knowledge by the public information offices could help resolve this problem.

Role definitions for EMS and other medical resources was another area of discussion by the group. A lack of knowledge among individual healthcare organizations about each other (across the spectrum of public, private, military, veteran, hospital staff, etc) creates an inadequate understanding of their collective resources and how they may be integrated.

Homeland Security and EMS

The breakout group participants expressed the sense that leaders in the Department of Homeland Security are unfamiliar with the role local EMS responders play in homeland security. They appear to assume they know and distribute resources based on these (often false) assumptions. EMS is not treated as a separate and important entity in homeland security, and is therefore often consolidated under various fire department and hospital initiatives. Further exacerbating the misperception is the lack of communication between the DHS and EMS providers. With no open communication, many group members felt that this problem will only continue. Participants also noted that Homeland Security guidelines do not generally encourage EMS jurisdictions to pool and share their resources, resulting often in spending valuable dollars on redundant equipment, training and other initiatives.

Finally, participants noted that the focus on homeland security, WMD, and mass casualty attacks distorts the real issues facing EMS providers. If EMS providers cannot adequately meet the service requirements during regular operations, how can focusing on mass casualty solutions help? Effective mass casualty preparedness should begin with improving the delivery of everyday services. As one EMS provider noted, “every day is a disaster situation.”

Breakout Group #4 – Retention, Recruitment, Training, etc.

Problems with the Bifurcated Fire/EMS System

Before any discussion of retention, recruitment, and training issues could take place, breakout group participants agreed upon a need to define **the type of system** personnel were working within. Participants pointed out the wide variation in EMS systems across the National Capitol area: ALS vs. BLS vs. EMT-I; all ALS; bifurcated systems that group Fire and EMS into completely separate divisions or department-like structures; two-tier vs. one-tier systems, etc. Furthermore, many EMS jurisdictions are currently in transition between ALS and BLS & vice versa, so that across the region, a variety of configurations exist to accomplish the EMS mission. It was also agreed that by discussing the EMS mission first, and then issues identified with each type of EMS system configuration, comments could be better organized.

A discussion of the EMS mission explored:

- Health care delivery – everyday and for major events
- Prevention
- Public Health.

It was apparent that further discussion and delineation of these focus areas, leading to the development of a regional consensus, may enhance the definition of EMS mission and measurable EMS objectives. This in turn may assist in addressing persistent EMS issues across the National Capitol area.

One of the problems associated with Bifurcated Fire/EMS Systems (separate Fire and EMS departments) was training. In this system, different levels of training become an issue and retention can be short. Another issue in the bifurcated system is the competition when recruiting paramedics and firefighters. Emphasis on one profession hurts recruiting in the other, and fails to address those individuals who want to do both jobs. A combined or separate system depends on the mission or goal of the department as well, and, in combined systems, those who want to be an EMT may not want to become a Firefighter, they may give up EMS or Fire certificates because don't want to do both. This can also hurt recruitment.

A recurring criticism was that in the combined system, the EMS element often is subject to attempts to solve EMS problems with Fire solutions. This criticism deserves greater scrutiny. A persistent question that carried through this concern is, 'Do managers have the experience to make decisions on Fire or EMS if they are embedded in the culture of opposite division'? Many statements about understanding "fire management" and "EMS management" as separate entities in terms of incident and personnel management were made and suggested that a closer examination of this predominant EMS management paradigm is necessary. Even if management itself is quite satisfied with the basis for their decision-making and systemic lay-out, it may be important to revisit this issue, as significant concern about upper-level decision-making emanated from within the ranks and from the EMS

community at all levels. The impression that EMS professionals feel that their input is undervalued in EMS-related decision-making became very apparent. Valid attempts to address this very legitimate concern might also improve some of the discontent that was apparent among participating street-level EMS providers. Participants characterized EMS decision-making as involving more critical thinking, while Fire tends to be more paramilitary-based in its decision-making structure.

Another important preliminary discussion was centered on basic assumptions concerning the emergency medical skills that firefighter's in the region possess. The consensus was that all firefighters in the NCR should be trained at least to the EMT level. The positive effect of this training on the region is that responses from fire units offer better services and response times in terms of patient care. The less satisfactory aspect is that only 5-10% of responders on fire trucks have ALS certification.

Recruitment of EMS Providers

The participant explored the question: Where are the pools for potential new EMS employees? A range of opinions and further questions were expressed:

1. Large vs. Small jurisdictions – how does recruiting work best for different sized departments?
2. Combination systems (volunteer vs. paid staff) – how do cross-training issues impact recruitment? How do you recruit firefighters, who will have to train for EMS and vice versa?
3. Sharing/stealing from other jurisdictions – employees will go to highest paying region for work, so how do smaller agencies keep people?
4. Already certified hires vs. those who need training: which is better?
5. Incentives: money, desire for the job – How do we motivate and create top quality employees who want to stay? Pay and retirement packages also affect recruitment. There is a need to have a good package to offer – pay must be good, benefits, pension, years until retirement (20 years is typical for Fire, 25 – 30 often for EMS – they must be equal!) – all are very important. Also, daycare options must be available or considered. It is very difficult to get daycare for 24 hour shifts and female EMT's and paramedics have trouble staying in the workforce without such support.
6. If you recruit from volunteer EMS you have already certified, will this just not rob the volunteer pool? Volunteers already have experience and know what they are getting into and are thus, the best people to recruit, but losing volunteers causes long-term funding issues.

There are certain questions about which recruitment techniques are worth investing time in getting better answers to.

1. Do we recruit earlier – in H.S. or even Junior High? How do we reach younger groups to get them interested? If we address them in 7th or 8th grade, we have to stay in contact until they are ready to graduate. There are several EMT programs in local high schools – how are they doing?

2. Does accessing the National Registry to find possible new recruits in the region really work well? (DC Fire reportedly sent 1,000 recruitment letters to NREMT-Paramedics, and only got 70 responses.) Are there any other lists of available potential employees? Should an agency take out ads in JEMS or other EMS magazines? There is a long turn-around time on this method, and it is expensive, does it pay off?

Another important question is about the size of the current crisis and shortage in paramedics and EMT's. Standards of care vary within the NCR region, which affects training considerations. There is a far greater shortage of Advanced Life Support (Intermediates, Paramedics, and other regional-only ALS providers, such as CRT's), which dramatically impacts any agency. Even though only 10% of EMS calls require ALS, an agency must staff and plan for ALS constantly. It was observed that the critical professional shortage in the field of EMS is not getting the attention deserved, while the nursing shortage has achieved national awareness and is front-page news on a regular basis. How can we address this? How can more attention be focused on this crisis? Paramedic shortages need to have a national spotlight shone on them. There needs to be a national advertising campaign and the problem needs more press.

Finally, a very important question is how many new recruits do we need as a region? Each jurisdiction needs to look at their call volume and project how many more people their program must have in training and set recruiting milestones.

Training

High quality pre-hospital care is a realistic, tangible goal for EMS training. In re-assessing training needs, the current status of pre-hospital care in the National Capitol area should be surveyed and from there, adequate projections of future needs developed. Another question in regards to training revisited the issue of the variation between EMS systems in the region, particularly combination Fire/EMS vs. separate fire and EMS agencies. Each type of system has problems associated with it. Requiring cross-training between Fire and EMS creates tension, and is not always successful. A question that factors into the training equation is this case is whether a difference exists between the personalities that become firefighters or paramedics. Can these different personalities do both jobs and enjoy the work? The training requirements differ, as do the physical and mental challenges of each job. Explaining future career requirements to trainees, i.e. that they may be training to be an EMT, but will need to become a firefighter in the future is also important.

Having separate Fire & EMS departments also causes tension in the ranks, especially when pay, benefit, pension, etc. packages differ between the divisions. However, even when the benefit packages are comparable, or even identical, tension seems to consistently exist between Fire and EMS. Perhaps this is due to the disparity of personalities and physical requirements needed of each specialty as discussed earlier. Another factor may be continual professional jealousy and competition – the grass is always greener on the other side of the fence. Currently the jury is still out on what the future for training will be for both BLS or

ALS. Participants felt strongly that higher standards are necessary in training, but there is already a high drop out rate in many programs. The current goal of the U.S. DOT curriculum for a new paramedic to practice is 2 years of college, culminating in an EMS-related Associates degree, but the much more prevalent EMS custom is Academy or Training Center education in advanced life support (*ALS) procedures for EMT-Intermediate providers due to time and money constraints. This is creating partially completed ALS training, to the Intermediate level, as the EMS practice standard, rather than the additional training required to achieve Paramedic certification. This is creating ALS training as the EMS practice standard, rather than Paramedic training. Many participants suggested that creating a regional training facility/academy may be a good solution to building regional training capabilities. There was an observation that training must address the medical liability associated with standards of patient care. For example, patient hand-off was cited in reference to transferring care. Once an EMT (of any level) establishes care, they must transfer the patient to equal or higher medical authority, or be liable for abandonment.

Practitioners felt that more hands-on experience is necessary for trainees. The question became "where can an employee receive such experience to incorporate the classroom component of their training." Participants also expressed a desire to see an increase in EMS entrance standards and testing, to exclude trainees who are in the program for the wrong reasons. Prescreening has been a controversial topic for a long time. What is a good prescreening tool to check for someone able to endure rigors of training first, then rigors of the profession? The type of testing required would have to look for more than mental stability or physical fitness. Another issue that received resounding support was enhancing the capabilities of EMTs, such as providing additional skills for administering certain medications. Another enhancement would be to facilitate the transition of training entry-level EMTs to EMT-I standards. Currently it is a huge jump from basic EMT to any ALS certification, so the "enhanced EMT" would have a better beginning grasp on ALS information, and will therefore become a better EMT –Intermediate or Paramedic.

Dr. Daniels of D.C. Fire & EMS emphasized the need to have testing at the end of the training process. EMT-Enhanced training has already been set-up in D.C. and a brief overview of how that system has been set up was provided. The District's training is all in the form of lectures. Breakout rooms are used to work on individual skills. Understanding protocols is a large part of the curriculum. Unit/Field work encompasses 3 days, but can take much longer. Fundamental skills are practiced until trainees show skill competency, only at that point are trainees released to go on to advanced skill work. In this way the program ensures that employees have practical skills. Test scores and level of attainment are also monitored to ensure quality employees and minimum passing grades. D.C. requires 80 hours of training, but some people require far more than 80 hours of training to pass both didactic tests and practical exams. As with training everywhere, funding is an issue.

Participants agreed that while there is a need for standardization in EMS education, it is difficult to give up local standards and requirements, which have no reciprocity across jurisdictional borders and produces certifications that are not transferable. Each jurisdiction or state is currently setting up skill sets that become part of definitions of EMT Basic and

Intermediate, but do not correspond to national norms. Standardizing these levels at the highest common denominator would increase the costs of education, but there will be more commonalities between jurisdictions and such a move could be better for regional emergency responses.

Retention

Participants expressed the importance of EMS Management focusing on "paying attention to and taking care of Paramedics and Firefighters." Both professions are high stress jobs, which should be reflected in equivalent pay scales. Commitment to employees needs to be a priority for retention purposes. Across the range of EMT levels, the job needs to be projected as a role that enhances careers and lives. "BLSers" (BLS practitioners) may particularly need to feel more valued, with a system of morale enhancements so that their role is better presented as a critical component of patient care.

Progressive career advancement and status must be made addressed. In terms of career advancement, some employees are content to stay in BLS positions, but many wish to move up into ALS positions or administrative positions that provide continuing advancement and professional challenge. The ability to make these changes was assigned great importance in terms of signaling potential, rather than stagnation, to EMS professionals. ALS qualifications generally mean that one can move on into Senior Staff positions (in-house advancement). A relevant question in the realm of career advancement becomes, "are there were enough positions to move up into?" The answer strictly within EMS systems is "probably not," and alternative advancements should be explored.

One of the pros in the combined system is that if personnel "burn out" in one field, a responder can stay within the system but switch to other tasks. Participants mentioned that there is a difference between those who leave the system completely, and those who stay, but move on to a different job. If someone stays in the system, but switches profession, it must be asked if this should be considered a true loss. Paramedics may need to be able to switch to the "fire side" on a regular basis to avoid burnout and see life from the "fire" perspective. Also, in many departments, the only way to get promoted is to be on the "fire side," and so paramedics see their career as "dead-end" unless they have significant fire experience. This REALLY hurts recruitment and retention!

"Burnout" is a huge problem, as many paramedics choose to give up their ALS certifications and lose their EMT status as an avenue to "getting off the ambulances and advance their careers" in other directions within their Fire/EMS system. On the surface, this appears contrary to logic because of the concomitant cut in pay, but "over-stressed" paramedics regularly attempt to make these changes after years on an ambulance. The workplace when assigned to a fire truck is much easier: there is time to sleep many nights, many fewer calls, and much less intensity in the types of cases seen. Shifts on a medic unit are tiresome, high-stress, with no sleep for 24 hours and continual calls. This trend may continue, since most departments with cross-training requirements have a limited time period (often 5 years) where an employee is required to maintain their ALS certifications.

- A great deal of agreement was expressed that EMS/Fire departments need to implement equal entry, incentive, promotion, pay, and retirement system in both professions, so that the disparities no longer create the divisiveness between Fire and EMS personnel. Training incentives were also seen as a method to help ensure employee retention.

All personnel in this closely linked system must be treated with the same amount of respect, in order to have a cohesive functional unit. This topic generated particular emotion, including bitterness, with EMS practitioners from one combined urban system.

Some participants observed that in addition to examining incentives, it was equally important to evaluate the disincentives incorporated into many EMS jobs. The first step to promote retention may be asking personnel why they are leaving, why they are burned out, and what management can do to help or perhaps change their plan.

Participants in this breakout group stressed that it is important to have a personal bond/relationship between management and employees. One-on-one communication was seen as highly significant to job satisfaction. One participant told a story about a paramedic that put in a request to leave his Medic Unit assignment, and give up his Paramedic certification and pay increase. His supervisor went to this employee's station to have a one-on-one conversation with the paramedic and found out that he was just really burned out, getting no sleep on duty nights, and dealing with many critical calls. The supervisor was able to talk the medic into maintaining his certification by transferring him to a fire unit at a slower station for a promised length of time. One-on-one communication was the key, and saved this valued medic from leaving his position.