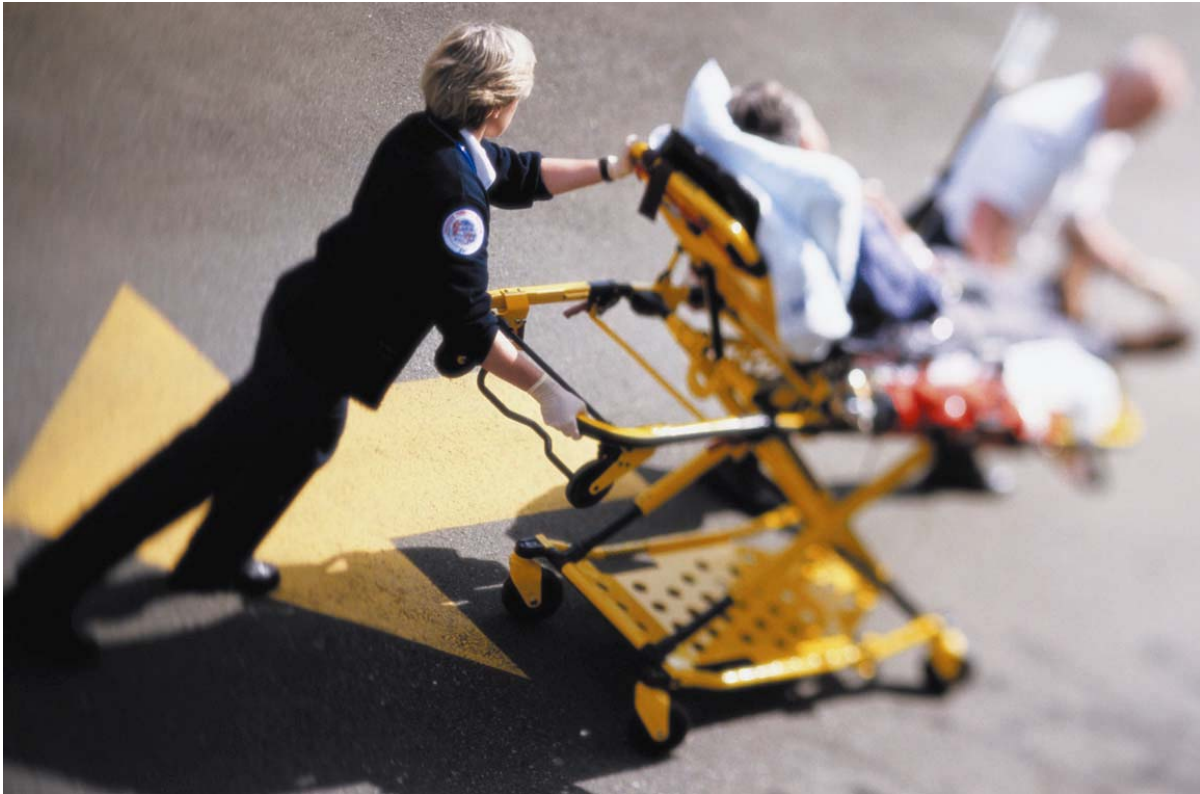


Back to the Future:
An Agenda for Federal Leadership of Emergency Medical Services



THE GEORGE WASHINGTON UNIVERSITY HOMELAND SECURITY POLICY INSTITUTE
ISSUE BRIEF

Frank J. Cilluffo, Daniel J. Kaniewski, Paul M. Maniscalco
Co-Chairs

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The Homeland Security Policy Institute (HSPI) draws on the expertise of The George Washington University and its partners from the academic, non-profit, policy and private sectors for a common goal of better preparing the nation for the threat of terrorism. HSPI frames the debate, discusses policy implications and alternatives and recommends solutions to issues facing America's homeland security policymakers. By linking academicians and scientists to decision makers at all levels of government, the private sector and the communities we live in, HSPI is working to build a bridge between theory and practice in the homeland security arena.

While consensus positions are sought and often achieved, the co-chairs take full responsibility for the opinions and recommendations herein.

For further information, please contact:

Homeland Security Policy Institute
The George Washington University
2300 I Street NW, Suite 721
Washington, DC 20037
Phone: 202-994-0295
hspi@gwu.edu
<http://homelandsecurity.gwu.edu>

America's first responders proudly serve their communities by responding thousands of times daily to calls for help from the citizens they serve. And as we have seen, catastrophic events such as terrorist attacks will demand significant resources and specialized capabilities from first responders. However, even in a post-9/11 environment, a fundamental component of the first responder community—Emergency Medical Services (EMS)—is a missing piece of the preparedness puzzle.

Today EMS needs a seat at the table, as first responder policy, funding and operations are debated at the federal level. To this end, EMS deserves an appropriate home in the federal bureaucracy that is afforded to the other first responder constituencies. Given the stated intention of the new Secretary to reexamine the Department of Homeland Security's mission and structure, now is the ideal time to provide EMS with the leadership, resources and stature that have been absent during its recent history. We therefore propose that EMS be transferred from its current home at the Department of Transportation to the Department of Homeland Security (DHS), where a U.S. Emergency Medical Services Administration (USEMSA) should be established.

EMS History: A federal perspective

By some accounts, pre-hospital medical care dates back to 1797 when Napoleon's chief physician implemented a triage and transport system to move the injured from the battleground to aid stations. In the 1860s, ambulance services came to Cincinnati and New York City. But it was not until a series of events in the mid-1960s that modern EMS was born. At the time, morticians—not medical providers—staffed 50 percent of the nation's ambulances.¹ In 1966, The National Academy of Sciences (NAS) authored a white paper, *Accidental Death and Disability: the Neglected Disease of Modern Society*, which drew attention to preventable injuries as the leading cause of death among persons between the ages of 1 and 37 and placed particular emphasis on the preventable injuries related to automobile collisions.² The report galvanized the government to address this “injury epidemic” and led to a federal focus on the emerging field and the development of standards for EMS equipment and training.³

As a result of the NAS report, Congress established an EMS office in the newly created Department of Transportation (DOT). Today EMS continues to be led at the federal level by the Department of Transportation, within its National Highway Traffic Safety Administration (NHTSA).⁴

¹ National Academy of Sciences, National Research Council, “Accidental Death and Disability: The Neglected Disease of Modern Society.” Washington D.C.: National Academy Press, 1966.

² *ibid*

³ Of note, the U.S. Fire Administration (USFA) was created as a result of the issues raised in the report “America Burning” (1973). The report highlighted the high numbers of fire deaths in the U.S. at the time and a subsequent report, *America Burning, Revisited* (1999), illustrated the results of fire prevention and education efforts. A similar follow-on report for EMS is desperately needed.

⁴ For simplicity, references to NHTSA (and its parent department, the U.S. Department of Transportation) are synonymously referred to as “DOT” in this document.

Several important events outside of the federal government's sphere of influence occurred during the late 1960s and into the 1970s⁵ and momentum gained with the designation of the Health Services and Mental Health Administration as the lead agency for EMS within the Department of Health, Education and Welfare (HEW).⁶ HEW provided additional funding for EMS capacity-building, culminating with the passage of the *EMS Systems Act of 1973*, which funded regional EMS systems. EMS systems across the country grew with this steady stream of federal funding, which reached its pinnacle during the 1970s.

The upward trend in EMS funding quickly fell in the 1980s, principally because the *Omnibus Budget Reconciliation Act of 1981* rolled EMS funding into the Preventative Health and Health Services block grants that gave States the discretion to determine funding priorities.⁷ Most States chose to fund programs other than EMS. After 1981, federal funding for EMS never returned to its previous levels and localities were left to bear the burden of funding EMS.

Without funding, the EMS efforts at the Department of Transportation and the Department of Health, Education and Welfare ground to a halt. By 1983, HEW had lost all of its EMS mission and DOT began to assume additional responsibilities, but because DOT was not vested with the authorities or funding provided to the HEW office, it had neither the carrot nor the stick necessary to encourage States to develop their EMS systems.⁸ This decentralized approach to EMS began a 20-plus year period of stagnation for EMS at the federal level and facilitated the disjointed approach to systems development and inconsistent standards that characterizes EMS today. Today, there is no one model for EMS delivery, oversight or scope of practice, as States and localities make their individual decisions with almost no assistance or guidance from the federal government.

EMS: A primer

Like its law enforcement and fire service counterparts, the nation's EMS agencies have a common function, but do not share a single operational structure. EMS can be delivered by either paid or volunteer personnel at a stand-alone local government EMS agency, fire department, hospital, for-profit or non-profit private company, or by other less common ways, such as a police department or an integrated public safety department. According to a 2004 *Journal of Emergency Medical Services*

⁵ Dr. J.F. Pantridge introduced the concept of emergency cardiac care in the pre-hospital setting in Northern Ireland in 1966 (see: Pantridge JF, Geddes JS. A mobile intensive-care unit in the management of myocardial infarction. *Lancet* 1967; 2(7510):271-273.). The innovative work of Dr. Pantridge caught the attention of Leonard Cobb in Seattle and Eugene Nagel in Miami, who first brought emergency cardiac care to American homes (see: Nagel EL, Hirschman JC, Mayer PW, Dennis F. Telemetry of physiologic data: an aid to fire-rescue personnel in a metropolitan area. *South Med J* 1968; 61(6):598-601, and Baum RS, Alvarez H, III, Cobb LA. Survival after resuscitation from out-of-hospital ventricular fibrillation. *Circulation* 1974; 50(6):1231-1235.)

The success of emergency medical services in saving lives in Vietnam (including helicopter evacuation), and the training of thousands of emergency medical technicians for the Army, further contributed to the development of modern EMS in America.

The case for pre-hospital advanced-level care was brought to the nation's living rooms in 1971 with the hit television program "Emergency." Seeing paramedics Johnny Gage and Roy DeSoto saving lives every week with their high-tech equipment and advanced procedures, the public soon began to demand paramedic-level care in their hometowns.

⁶ HEW was the predecessor to the U.S. Department of Health and Human Services (HHS).

⁷ In most states, EMS competes for these dollars with the Women, Infants and Children (WIC) program and various other public health programs. In Maryland, the rat eradication program was one such public health program.

⁸ Kuehl AE. *Prehospital Systems & Medical Oversight*. 2nd ed. Missouri: Mosby Lifeline, 1994: 19.

study, 44.89 percent of EMS systems are fire-based and 55.11 percent are hospital-based, private, stand-alone government agency or another type of EMS organization.⁹

The nation's 840,000-plus EMS personnel are trained, generally speaking, to either the basic level (EMT-Basic) or advanced level (EMT-Paramedic).¹⁰ EMT-Basics can assess and stabilize patients' immediate needs, whereas paramedics provide additional interventions, such as intravenous medication delivery, cardiac monitoring and defibrillation, and advanced airway procedures. Many EMS providers also have specialized training in the areas of patient extrication and rescue, incident command, hazardous materials response, crisis intervention, mass casualty response and injury prevention.¹¹ Each State sets its own requirements for training and certification, though the EMT-Basic and EMT-Paramedic curricula are based upon a national standard developed by DOT.

Regardless of the delivery method or level of training, EMS strives to quickly respond to, care for and transport the sick and injured during their time of need. Such emergency assistance is required for the thousands of heart attacks, automobile collisions and other "everyday" emergencies. But there is also a significant need for EMS response for infrequent, but high-consequence crises, such as natural disasters or terrorist acts. EMS must therefore be adequately prepared for both the ordinary and extraordinary events.

Key Issues

Several significant issues must be addressed if EMS is to be a true partner in the first responder community—responding to daily emergencies and mass casualty events alike.

Funding

Though EMS providers are roughly equal in numbers to firefighters and law enforcement officers, they receive only *four percent* of the first responder funding allocated by DHS.¹² This is unsurprising from the federal perspective, given that EMS is not located in DHS, but disturbing, given that EMS is as critical a component of the first responder community as the other groups. This means, for example, that following a weapons of mass destruction (WMD) attack, firefighters and law enforcement officers will be donning their personal protective equipment that was paid for by the federal government, while EMS providers stand unprotected on the sidelines, unable to treat the patients that are in need of their immediate lifesaving help. The only other option available to EMS personnel will be to enter a contaminated environment unprotected and thus face almost certain bodily harm. Unprotected EMS personnel will become victims themselves, leading to further casualties and creating an unmitigated disaster.

Unlike law enforcement and the fire service, EMS has no grant programs dedicated to its basic operating needs.¹³ EMS has many unfilled equipment needs (personal protective equipment and

⁹ Journal of Emergency Medical Services, Platinum Resource Guide, Key EMS Statistics
<http://www.jems.com/jems/2004resources/guide1.html>

¹⁰ *ibid*

¹¹ For further discussion on the role of EMS during mass casualty incidents see: Christen HT, Maniscalco PM. *Mass Casualty and High-Impact Incidents: An Operations Guide*. Prentice Hall, 2002; Maniscalco PM, Christen HT. *Understanding Terrorism and Managing the Consequences*. Prentice Hall, 2001; Christen HT, Maniscalco PM. *The EMS Incident Management System: Operations for Mass Casualty and High-Impact Incidents*. Pearson Education, 1998.

¹² U.S. Department of Homeland Security. "Support for EMS Provided by the DHS Office of State and Local Government Coordination and Preparedness." A Report to the Committees on Appropriations of the United States Senate and House of Representatives. Washington, D.C., May 2004: 42.

¹³ The fire service has the Assistance to Firefighter Grant Program (<http://www.firegrantsupport.com/>)

specialized equipment for medical interventions and rescue), as well as demands for the recruitment and retention of personnel, particularly volunteers.

Data collection

EMS lacks a data collection program similar to the federal programs provided to its first responder counterparts. Thanks to the U.S. Fire Administration, we know that there were 1.6 million fires causing \$12.3 billion in damage during 2003.¹⁴ And the Bureau of Justice Statistics tells us that 1,068,500 violent crimes were reported in 2003 and police made 597,000 arrests.¹⁵ No federal agency collects data on EMS responses—a major shortcoming that undercuts the EMS community’s ability to conduct research to improve itself, or even justify its mission.

Needs assessment

There has never been an assessment of the needs of EMS in the United States. There has, however, been a recent effort for the fire service. In 2002, the U.S. Fire Administration commissioned the National Fire Protection Association (NFPA) to conduct a modern needs assessment of the American fire service. According to NFPA President James M. Shannon:

The results of this study identify many areas where additional resources are needed for the fire service to operate effectively and safely, in both traditional response and the new challenges faced by homeland security. Firefighters and the citizens they protect deserve the best we have to offer.¹⁶

Given the value of this study to the fire service, a similar study for EMS would be equally valuable and is critically needed.

Training academy

There is no national training academy dedicated to emergency medical services providers. The Federal Emergency Management Agency provides firefighters with the National Fire Academy and emergency managers with the Emergency Management Institute. Police officers have opportunities with such training sites as the Federal Law Enforcement Training Center and the FBI Academy. Although EMS providers can participate in courses held at some of these sites, none are focused exclusively on EMS training and educational needs and none integrate well the medical aspects of emergency response. The existing inventory of federally funded courses that address EMS-specific operational or medical response issues is minimal at best.¹⁷

Beyond the short, topic-based training courses, the broader educational programs taught at the flagship centers for police and firefighters have brought us the leaders for the next decades in the fire service and spawned aggressive training and educational programs all over the country. Clearly, the public would benefit if the same attention were paid to the professional development of EMS providers.

Bureaucracy

Unlike the fire service, with its home in the Department of Homeland Security’s USFA, EMS does not have a strong advocate in the federal bureaucracy. The irony here is that, unlike the other groups,

and law enforcement has the Community Oriented Policing Services (COPS) program (<http://www.cops.usdoj.gov/>).

¹⁴ U.S. Fire Administration, “fire statistics”: <http://www.usfa.fema.gov/statistics/quickstats/>.

¹⁵ U.S. Department of Justice, Bureau of Justice Statistics, “Four measures of serious violent crime” <http://www.ojp.usdoj.gov/bjs/glance/tables/4meastab.htm>.

¹⁶ U.S. Fire Administration, “FEMA, USFA and NFPA national study identifies service gaps in America’s fire departments,” Release No.: 03-014, January 22, 2003: www.usfa.fema.gov/about/media/2003releases/03-014.shtm

¹⁷ Fewer than 10 federal courses specifically focus on EMS requirements and operations.

EMS has many of its standards codified in law. Such standards include the regulations for ambulances and EMS training curricula.¹⁸ Unfortunately, though the federal government already possesses much of the authority to provide it with guidance and support, EMS is buried deep in the bureaucracy in DOT, making it nearly impossible to effect change or advocate policies. At the federal level, EMS is an all-but-forgotten component of emergency response, and thus needs to be in a federal department that embraces its first responder mission.

These shortcomings reflect the lack of federal leadership on EMS. Two reports addressed these issues, but fell short in their recommendations.

¹⁸ U.S. Department of Transportation, National Highway Traffic Safety Administration, EMS National Standard Curricula: <http://www.nhtsa.dot.gov/people/injury/ems/nsc.htm>; U.S. General Services Administration, Federal Specifications for the Star-of-Life Ambulance, KKK-A-1822E: http://www.gsa.gov/gsa/cm_attachments/GSA_DOCUMENT/ambulanc_1_R2FI5H_0Z5RDZ-i34K-pR.pdf.

EMS shortcomings highlighted

With much anticipation from the EMS community, a working group funded by the Department of Transportation developed the *EMS Agenda for the Future* in 1996.¹⁹ One of the report's goals highlighted the need for federal EMS leadership. Written in the context of an ideal state for EMS, it proposed the following:

There is a federal lead EMS agency. The agency is mandated by law, sufficiently funded and credible, and is recognized by the health care and public safety systems. It directs nationwide EMS development, provides coordination among federal programs/agencies affecting EMS, serves as a central source for federal EMS-related research and infrastructure creation funding, provides an information clearinghouse function, and oversees development of national guidelines.²⁰

Unfortunately this dream has not become reality. The *EMS Agenda for the Future*, a much heralded effort in the 1990s, has since all but been forgotten. The subsequent "implementation guide" does little more than to encourage the EMS stakeholder organizations to form partnerships.²¹

A recent report by New York University highlighted well some of the issues EMS faces, but its solution to the problems—pointing to the existing federal inter-agency committee—is inadequate.²² The Federal Interagency Committee on EMS (FICEMS) is a toothless tiger that focuses on EMS coordination between federal agencies with limited EMS roles. It has no ability to lead federal policy, influence budgets or address state or local EMS issues. Subsequent legislation introduced by Senator Susan Collins (R-ME) and Congressman Joel Hefley (R-CO) proposed this FICEMS "solution."²³ Such legislation will do virtually nothing to address the challenges EMS faces.

A much more comprehensive—and ambitious—effort is necessary if we are to address the federal EMS leadership and funding gaps that have persisted for more than two decades.

¹⁹ EMS Agenda for the Future, National Highway Traffic Safety Administration, U.S. Department of Transportation, April 16, 1996:

http://www.nhtsa.dot.gov/people/injury/ems/ems_agenda.html

²⁰ EMS Agenda for the Future, National Highway Traffic Safety Administration, U.S. Department of Transportation, April 16, 1996: <http://www.nhtsa.dot.gov/people/injury/ems/agenda/emsman.html#LEGISLATION>

²¹ EMS Agenda for the Future Implementation Guide, National Highway Traffic Safety Administration, U.S. Department of Transportation, February, 1998: <http://www.nhtsa.dot.gov/people/injury/ems/agenda/>

²² Emergency Medical Services: The Forgotten First Responder" Center for Catastrophe Preparedness and Response, New York University, March 2005: <http://www.nyu.edu/ccpr/pdf/NYUEMSreport.pdf>

²³ S.611, introduced by Senator Susan Collins and HR 1240, introduced by Congressman Hefley

A new home for EMS: The U.S. Department of Homeland Security

EMS has no true federal advocate. It is housed in a small program office of the Department of Transportation, National Highway Traffic Safety Administration (NHTSA), which itself focuses little on EMS. In fact, there is no mention of EMS or any related function on the “Who we are and what we do” section of the NHTSA website:

NHTSA is responsible for reducing deaths, injuries and economic losses resulting from motor vehicle crashes. This is accomplished by setting and enforcing safety performance standards for motor vehicles and motor vehicle equipment, and through grants to state and local governments to enable them to conduct effective local highway safety programs.

NHTSA investigates safety defects in motor vehicles, sets and enforces fuel economy standards, helps states and local communities reduce the threat of drunk drivers, promotes the use of safety belts, child safety seats and air bags, investigates odometer fraud, establishes and enforces vehicle anti-theft regulations and provides consumer information on motor vehicle safety topics.

NHTSA also conducts research on driver behavior and traffic safety, to develop the most efficient and effective means of bringing about safety improvements.²⁴

While DOT/NHTSA might have been the appropriate home for EMS in the federal government during the early years of EMS when its focus was on transporting automobile accident victims, EMS has long outgrown such vestigial ties.²⁵ The time is ripe for EMS to move to a more suitable federal agency.

We are not alone in our desire for EMS to have a true federal leader. Outside experts, such as the Advisory Panel to Assess the Domestic Response Capabilities for Terrorism Involving Weapons of Mass Destruction (a.k.a. “Gilmore Commission”) have called for a federal EMS agency to support EMS operations and systems issues.²⁶

The most appropriate solution to the EMS quandary of being housed in a department in which it no longer fits is to move it to a department that leads the federal government’s first responder efforts.

The Department of Homeland Security is the ideal home for EMS at the federal level. One of the department’s primary missions, to “minimize the damage from potential attacks and natural disasters” fits well with the role of EMS as an essential member of the first responder community. DHS has developed and now administers the National Incident Management System (NIMS). This system emphasizes interoperability and prescribes the role of EMS in the incident response template.²⁷ Thus, it is logical that, since EMS is a key component of NIMS, it be incorporated into DHS.

²⁴ National Highway Traffic Safety Administration, About NHTSA, “Who we are and what we do,”: <http://www.nhtsa.dot.gov/>.

²⁵ While EMS responses to traffic accidents continue, responses to other acute medical emergencies, notably cardiac emergencies, have increased dramatically, eclipsing the core discipline represented by NHTSA. Moreover, dramatic changes in the national security landscape require the creation and management of specialized competencies and disciplines that fall squarely within the Department of Homeland Security.

²⁶ The Fifth Annual Report to the President and the Congress of the Advisory Panel to Assess the Domestic Response Capabilities for Terrorism Involving Weapons of Mass Destruction, December 15, 2003, 28: http://www.rand.org/nsrd/terrpanel/volume_v/volume_v_report_only.pdf.

²⁷ Christen HT, Walsh DW. “The new normalcy.” *Journal of Emergency Medical Services*, 2005, Vol 30, No. 4, pg 68.

Within DHS, EMS needs an advocate for the funding, training, education and exercising as well as the equipment afforded to other first responder groups. Therefore, we call for the establishment of the U.S. Emergency Medical Services Administration (USEMSA) that should be modeled after, and be at an equivalent level to, the U.S. Fire Administration (USFA). As is the case for the USFA, USEMSA should have a high-ranking administrator and adequate funding appropriated to the office itself and for EMS grants to states and localities. It should have the informal powers, such as access to senior DHS leaders and a seat at the table when first responder policies are discussed and debated. It should also have an associated national training center.

In summary, the USEMSA should possess, at a minimum, the following results-oriented characteristics:

- Lead national EMS policy
- Be funded at an appropriate level for this critical national mission
- Manage and update existing EMS education and vehicle standards
- Be the EMS providers' voice in the federal government
- Examine EMS responder safety issues
- Collect and disseminate EMS data, as USFA and the Bureau of Justice Statistics do for the other first responder constituencies
- Be the central clearinghouse for EMS information, funding and standards
- Manage national training programs
- Conduct research, including needs and capabilities assessments

Though this proposal is ambitious, it is not unprecedented in scope. When DHS was created in 2002, critics argued that the bureaucracy could not be rapidly overhauled. Today, with 22 agencies and 180,000 employees, DHS has accomplished its goal of consolidating the nation's homeland security efforts.^{28 29}

Without appropriate representation and integration into the federal government's first responder activities, EMS issues will continue to go unaddressed, and lack of policy coherence and funding will continue unabated. Some would argue that EMS is in the right place in the federal bureaucracy since transporting patients is what EMS does. This view fails to recognize the evolution of EMS over the past 30 years and continues the misperception of EMS as merely a transportation mode. EMS must not fall victim to what *Peter Principle* author Laurence J. Peter found: "Bureaucracy defends the status quo long past the time when the quo has lost its status."

Conclusion

In Secretary Michael Chertoff's March 16, 2005 vision speech at The George Washington University, he stated, "Old categories, old jurisdictions, old turf will not define our objectives or the measure of our achievements. Because bureaucratic structures and categories exist to serve our mission, not to drive it." Moving EMS into DHS with the funding and status it deserves resonates well with the Secretary's mission-oriented vision.

²⁸ U.S. Department of Homeland Security, Strategic Plan, February 23, 2004: <http://www.dhs.gov/dhspublic/display?theme=10&content=3240>.

²⁹ Of particular note, the United States Coast Guard—with more than 50,000 members—was transferred from the Department of Transportation when DHS was created. With such a significant precedent, transferring the handful of employees from the DOT EMS office to DHS should be simple by comparison.

We should pull a page from the history books and see, that in the 21st century, EMS deserves a renaissance to its high water mark 30 years ago. By reinvigorating EMS leadership at the federal level in a department that embraces first responders, EMS personnel on the front lines will be better prepared to respond to the full spectrum of emergencies—from the ordinary to the extraordinary. And since better prepared EMS providers mean a better prepared nation, this is one lesson we cannot afford to forget.

About the Co-Chairs

Frank J. Cilluffo is Director of The Homeland Security Policy Institute at The George Washington University. Cilluffo joined GW from the White House where he served as Special Assistant to the President for Homeland Security. In his capacity as Special Assistant to the President for External Affairs, Cilluffo was responsible for engaging and building partnerships with the private sector, academic, and state and local officials and emergency responders on homeland security policies and initiatives. Prior to his White House appointment, Cilluffo spent eight years in senior policy positions with the Center for Strategic and International Studies, where he chaired numerous committees and task forces on homeland defense, counterterrorism, transnational crime, and information warfare and information assurance. He is widely published on homeland security topics and has testified before the United States Congress on a number of occasions.

Daniel J. Kaniewski is Deputy Director of the Homeland Security Policy Institute at The George Washington University. He previously served as a Congressional Liaison for Terrorism Preparedness and Consequence Management at the Federal Emergency Management Agency. Prior to 9/11 Kaniewski was a Homeland Security Fellow to Congressman Curt Weldon (R-PA) and subsequently served in the same capacity to Congressman J.C. Watts (R-OK). Earlier, he was the Emergency Medical Services Advisor to the Congressional Fire Services Institute, a non-profit organization dedicated to educating members of Congress on fire and EMS issues. Kaniewski holds a Bachelor of Science degree in Emergency Medical Services from The George Washington University, a Master of Arts degree in National Security Studies from the Georgetown University School of Foreign Service and is a Nationally Registered Emergency Medical Technician-Paramedic.

Paul M. Maniscalco is an Assistant Professor of Health Sciences at The George Washington University. He is a former Deputy Chief / Paramedic for the City of New York. Chief Maniscalco has more than 30 years of public safety response, supervisory and management experience. During his tenure, he has had the responsibility of responding to and managing a wide array of events ranging from aviation and rapid transit emergencies and natural disasters to civil disturbances and acts of terrorism. Chief Maniscalco has also been engaged in command roles for managing special events, such as dignitary visits, national political conventions and a wide variety of mass gatherings. Maniscalco was an appointee to the Gilmore National Terrorism Commission where he served as the Chairman of the State and Local Response Panel and also the Threat Reassessment Panel. He earned his Bachelors degree in Public Administration from the City University of New York and a Master of Public Administration - National Security & Foreign Policy from the New York University Wagner Graduate School of Public Service.