STATE OF FLORIDA

A REASSESSMENT OF EMERGENCY MEDICAL SERVICES

November 12-14, 2013

National Highway Traffic Safety Administration
Technical Assistance Team

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BACKGROUND

Injury is the leading cause of death for persons in the age group one through 44 as well as the most common cause of hospitalizations for persons under the age of 40. The financial costs of injuries are staggering: injuries cost billions of dollars in health care and social support resources. In 1995, for example, the lifetime costs of all injuries were estimated at $260 billion annually. These estimates do not include the emotional burden resulting from the loss of a child or loved one, or the toll of severe disability on the injured person and his or her family. Each year over 33,000 people lose their lives on our nation's roads, and approximately 70 percent of those fatalities occur on rural highways. The National Highway Traffic Safety Administration (NHTSA) is charged with reducing death and injury on the nation's highways. NHTSA has determined it can best use its limited EMS resources if its efforts are focused on assisting States with the development of integrated emergency medical services (EMS) programs which include comprehensive systems of trauma care.

To accomplish this goal, in 1988 NHTSA developed a Technical Assistance Team (TAT) approach which permitted states to utilize highway safety funds to support the technical evaluation of existing and proposed emergency medical services programs. Following the implementation of the Assessment Program, NHTSA developed a Reassessment Program to assist those states in measuring their progress since the original assessment. The Program remains a tool for States to use in evaluating their statewide EMS programs. The Reassessment Program follows the same logistical process, and now uses the same ten component areas plus the area of preparedness with updated standards. The standards now reflect current EMS philosophy and allow for the evolution into a comprehensive and integrated health management system, with regional accountable systems of care, as identified in the 2006 IOM Report on the Future of Emergency Care. NHTSA serves as a facilitator by assembling a team of technical experts who demonstrate expertise in emergency medical services development and implementation. These experts demonstrate leadership and expertise through involvement in national organizations committed to the improvement of emergency medical services throughout the country. Selection of the Technical Assistance Team is also based on experience in special areas identified by the requesting State. Examples of specialized expertise include experience in the development of legislative proposals, data gathering systems, and trauma systems. Experience in similar geographic and demographic situations, such as rural areas, coupled with knowledge in providing emergency medical services in urban populations is essential.

The Florida Department of Health, Office of Emergency Medical Services Sections requested the assistance of NHTSA. NHTSA agreed to utilize its technical assistance program to provide a technical reassessment of the Florida Statewide EMS program. NHTSA developed a format whereby the EMS staff coordinated comprehensive briefings on the EMS system.

The TAT assembled in Tallahassee, Florida on November 12 -14, 2013. For the first day and a half, over 20 presenters from the State of Florida, provided in-depth briefings on EMS and trauma care, and reviewed the progress since the 1993 Assessment. Topics for review and discussion included the following:

General Emergency Medical Services Overview of System Components

- Regulation and Policy
- Resource Management
- Human Resources and Education
- Transportation
- Facilities
- Communications
- Trauma Systems
- Public Information and Education
- Medical Direction
- Evaluation
- Preparedness

The forum of presentation and discussion allowed the TAT the opportunity to ask questions regarding the status of the EMS system, clarify any issues identified in the briefing materials provided earlier, measure progress, identify barriers to change, and develop a clear understanding of how emergency medical services function throughout Florida. The team spent considerable time with each presenter so they could review the status for each topic.

Following the briefings by presenters from the EMS Section, public and private sector providers, and members of the medical community, the TAT sequestered to evaluate the current EMS system as presented and to develop a set of recommendations for system improvements. When reviewing this report, please note the TAT focused on major areas for system improvement.

The statements made in this report are based on the input received. Pre-established standards and the combined experience of the team members were applied to the information gathered. All team members agree with the recommendations as presented.

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The Technical Assistance Team (TAT) would like to acknowledge the Florida Department of Health, Bureau of Emergency Medical Oversight, for their support in conducting this assessment and the State Highway Safety Office for supporting the assessment process.

The TAT would like to thank all of the presenters for being candid and open regarding the status of EMS in Florida. Each presenter was responsive to the questions posed by the TAT which aided the reviewers in their evaluation. Many of these individuals traveled considerable distance to participate.

Special recognition and thanks go to, John Bixler, Chief, EMS Section, and Desi Lassiter, and the rest of the EMS Section staff and all the briefing participants for their extraordinary efforts and well-prepared presentations.

INTRODUCTION

Legend suggests that Ponce de Leon was searching for the Fountain of Youth when he arrived in Florida in 1513 as the earliest European explorer of the new world. Now in 2013 the Florida EMS System seeks to renew itself in the waters of the mythical Fountain to help find vigor and vitality.

The Sunshine State was admitted to the Union in 1845 and is the 4th most populous state of the union. Although there are twenty metropolitan statistical areas in the state, which represent high-density population areas, there are large tracts of low-density land with difficult terrain features, notably swamp. The 1,350 miles of coastline are the longest coastline of any of the contiguous United States which places much of the population within close proximity to water. Though the coastal waters can be avoided with proper planning, it is far more challenging to avoid the hurricanes that commonly threaten the state.

The EMS Section in the Bureau of Emergency Medical Oversight under the Department of Health leads and manages a mature Emergency Medical Services system that historically is well respected nationally. However, within the past two years there has been discord and program uncertainties that has resulted in unwanted local, regional and national spotlights. Subsequent internal review and assessment has been augmented by prompt request for external review by panels of national experts. The Trauma System Consultation Report by the American College of Surgeons was the first such review and this Technical Assistance Team report is a complementary review of the overarching EMS system.

A. REGULATION AND POLICY

Standard

Each State should embody comprehensive enabling legislation, regulations, and operational policies and procedures to provide an effective statewide system of emergency medical and trauma care and should:

- Establish the EMS program and designate a lead agency;
- Outline the lead agency's basic responsibilities and authorities including licensure and certification including the designation of emergency medical services regions;
- Require comprehensive EMS system planning;
- Establish a sustainable source of funding for the EMS and trauma system;
- Require prehospital data collection which is compatible with local, State and national efforts such as the National EMS Information System (NEMSIS) and evaluation;
- Provide authority to establish minimum standards related to system elements such as personnel, services, specialty care facilities and regional systems and identify penalties for noncompliance;
- Provide for an injury/trauma prevention and public education program;
- Integrate the special needs of children and other special populations throughout the EMS system; and
- Integrate pediatric EMS needs into State statutes, rules and regulations.

All of these components, which are discussed in different sections of this guideline, are critical to the effectiveness of legislation, regulations or policies/procedures which are the legal foundation for a statewide EMS system.

Status

Florida Statute 381.0205, Emergency Medical Services (EMS), requires the Department of Health to provide a statewide EMS program pursuant to Chapters 395 (Trauma), and 401 (EMS). The Florida Emergency Medical Services Section is an office designated by the Department of Health (DOH) under the leadership of the Florida Surgeon General. The EMS Section carries out its program development and regulatory responsibilities under the authority in Chapter 401, Part III of the Florida statutes. The

DOH EMS rules are designated in Section 64J of the Florida Administrative Code. Sections 64J-1, 64J-2, and 64J-3 provide operational policies for emergency medical care, trauma care, and dispatching.

In February 2013, the American College of Surgeons Committee on Trauma (ACS/COT) conducted a Trauma Systems Consultation visit at the request of the DOH. One of the recommendations from the ACS consultation asked the state to collaborate with the Florida Department of Transportation Governor's Highway Safety Program to initiate and conduct a National Highway Traffic Safety Administration (NHTSA) EMS System Reassessment. The last NHTSA EMS assessment was conducted in 1993. Many of the recommendations of the 1993 assessment have been implemented and have obviously contributed to the many successes of the system to date.

One of those successes is the Emergency Medical Services Tracking and Reporting System (EMSTARS).Unfortunately participation is voluntary with only approximately 75% of the 3.6 million annual patient encounters reported in the system. Prehospital data is an essential component of the system and a valuable tool used in planning for improving outcomes among the state's residents and visitors requiring emergency care.

Some agencies currently not participating in the EMSTARS system expressed concern about the patient confidentiality of the data submitted and the information derived from it. There is a broad perspective that further clarification of these issues is needed.

From the presentations during this assessment it was clear from the EMS stakeholders that the EMS Section is not staffed at a level to meet its current statutory requirements and to ensure the health and safety for the state's citizens. This is particularly true in the area of ambulance inspectors. Currently, the EMS Section has only two inspectors for over 4,000 permitted ambulances in the state. Current state law has no time requirement as to when ambulances should be inspected. Vehicle inspections are essential in providing the public with the assurance of safe and appropriate care being delivered by the statewide EMS system. In order to meet the funding requirements of additional inspectors the State will need to look at all funding options to include possibly increasing revenue into the State EMS Trust Fund.

Increasing the revenue for the EMS Trust Fund will also assist in better meeting the needs of the local EMS agencies. Currently, many local grant applications are denied, not because of the lack of need, but due to insufficient funding to meet the local EMS critical needs. Annually, less than 30% of requested funds have been awarded.

The EMS Section contracts with the Florida Association of EMS Medical Directors (FAEMSMD) to provide statewide medical direction and collaborate with each local medical director to help ensure state of the art care is being delivered to the citizens throughout the state. The state medical director is a critical component of an EMS system. Currently, the EMS Section Medical Director position is not defined or required in statute. In order to effectively carry out the functions of the statutory requirements of

the department a state medical director position and his or her role needs to be codified. In addition, sufficient hours should be allocated for the medical director to provide the necessary support to the local EMS agencies and their medical directors.

The department and stakeholders support EMS protocols but they are now driven by the local agencies. While this has benefit there is no statewide baseline established to standardize prehospital care. Collaboration among EMS medical directors, EMS providers, counties, and the trauma system is important for establishing a statewide minimum set of protocols that is used by all licensed EMS agencies. This could essentially establish the floor for care being provided statewide and medical oversight while still allowing the flexibility at the local level. The requirements should ensure that every person in Florida has access to a consistent baseline of care for medical emergencies.

Florida is a diverse state but no area of the state is immune from time sensitive disease events such as trauma, stroke, ST-Elevation Myocardial Infarction (STEMI), and pediatric emergencies. The state needs to make every effort to develop a system that facilitates persons facing these time sensitive medical emergencies to arrive at a treatment facility that can provide optimal care in the most expeditious and efficient manner. In order to accomplish this, destination protocols need to be established as part of the statewide baseline protocols.

Since the 1993 NHTSA EMS assessment many changes have occurred in the way EMS is provided. Specialty Care services are now being offered, particularly for inter-hospital transfers of critical patients that include critical neonatal and pediatric patients. EMS systems are using specially designed vehicles and equipped transport units such as neonatal mobile intensive care units and helicopters. These vehicles also may require a crew with specialized education and training. Current law or rule does not define specialty vehicles or address equipment and staffing needs for this type of service.

Recommendations

The Department of Health should:

- **Codify the statewide EMS medical director position with defined roles and responsibilities.**

- **Adopt rules to require that all EMS agencies participate in the EMSTARS system and enter data daily for each patient encounter.**

- Adopt rules to require ambulances to be inspected either on an annual or bi-annual schedule and provide sufficient staff to carry out this function. Consider

increasing revenue in the EMS trust fund to support this effort.

- Adopt rules to require the development of baseline statewide protocols for all EMS providers that allow sufficient flexibility at the local level to adequately meet the diverse needs of the counties. Include the requirement that each local agency have protocols that address transports of time sensitive diseases.

- Adopt rules to define specialty care vehicles and include minimum equipment and staffing requirements to adequately meet the needs of the patient being transported.

The Legislature should:

- Enact legislation to clearly protect medical records compiled and maintained by the department for those participating in the statewide EMS and Trauma System to include EMS providers and hospitals in connection with dispatch, response, treatment, or transport of individual patients.

B. RESOURCE MANAGEMENT

Standard

Each State EMS lead agency should identify, categorize, and coordinate resources necessary for establishment and operation of regionalized, accountable EMS and trauma systems. The lead agency should:

- Maintain a coordinated response to day-to-day emergencies as well as mass casualty incidents or disasters and ensure that resources are used appropriately throughout the State;
- Have policies and regulations in place to assure equal access to basic emergency care for all victims of medical or traumatic emergencies;
- Provide adequate triage, including trauma field triage, and transport of all patients by appropriately certified personnel (at a minimum, trained to the emergency medical technician [EMT] level) in properly licensed, equipped, and maintained ambulances;
- Provide transport to a facility that is appropriately equipped, staffed and ready to administer to the needs of the patient including specialty care hospitals (section 4: Transportation);
- Appoint an advisory council, including pediatric EMS representation, to provide broad-based input and guidance to the state EMS system and to provide a forum for cooperative action and for assuring maximum use of resources; and
- Coordinate with State Highway Safety Agency and other State Agencies in the development of the Strategic Highway Safety Plan to ensure that EMS system information is used to evaluate highway safety problems and to improve post-crash care and survivability.

Status

Florida is a "home rule" state where the authority of the 67 county governments is the cornerstone of how EMS services are provided at the local level. Statute requires that EMS services be provided in all counties and the counties are responsible for issuing a Certificate of Public Convenience and Necessity (COPCN) for any EMS agency wishing to provide services within their jurisdictions. This system is designed to ensure that sufficient numbers of ambulances and trained personnel are available to provide care and transportation. There is no structured regional system of planning or care in the EMS system. Instead, constituent communication comes through the State EMS Advisory Council, individual counties and other local governments. Thus, management,

oversight and understanding of the state's extensive EMS resources is an ongoing partnership between local agencies, county governments and state government with numerous input pathways to the DOH and other state level policy makers. Although there are informal regional affiliations among some provider agencies in various parts of the state, there is an opportunity to enhance information flow and recognize regional needs through the development of more formalized regional EMS advisory councils. These councils would provide the catalyst for improved local input, protocol development and resource sharing as well as possibly providing extended services on behalf of the DOH and the EMS Section. This approach could significantly improve coordination between EMS agencies, facilities and other EMS system participants.

Extensive activities have revolved around strategic planning in a variety of areas of the state's emergency response system. The State EMS Advisory Council, in coordination with the EMS for Children Committee, works with the Department of Health's EMS Section to keep an updated strategic plan in place. This plan is now updated every five years and serves as one of the prime guiding documents for system-wide development and improvements. In addition to the statewide strategic plan for EMS, Florida has extensive experience and success in developing comprehensive disaster plans, (i.e. the Ambulance Deployment Guideline and the Florida Air Medical Services Disaster Response Plan), that have proven on multiple occasions to be a best practice across the nation.

With 274 licensed EMS agencies supported by 66,244 certified EMS providers, Florida has developed a system of care and transportation that serves the diversity of both metropolitan and rural areas. Although significant work has been done to establish a system of resource management and deployment that is both contemporary and flexible, the resources available to the EMS Section to accomplish its regulatory responsibilities are significantly limited. There appears to be insufficient personnel resources assigned to a number of critical resource functions such as ambulance inspections, education oversight and system monitoring. Opportunities to expand the EMS Section's capabilities in these and other program areas should be prioritized.

Recommendations

The Department of Health and the State EMS Advisory Council should:

- **Ensure that the resources necessary to accomplish all statutory, regulatory and organizational mandates of the EMS Section are implemented in a timely and efficient manner.**

- **Evaluate and consider establishing formalized regional systems of planning and care to better support EMS system development, resource utilization and coordination.**

The State EMS Advisory Council should:

- Establish a broad based advocacy effort that includes participation from the EMS for Children Committee, the state's EMS related associations and other EMS system stakeholders to better inform legislators and policy makers as to the ongoing needs of Florida's EMS system.

C. HUMAN RESOURCES AND EDUCATION

Standard

Each State should ensure that its EMS system has essential trained and certified/licensed persons to perform required tasks. These personnel include: first responders (e.g., police and fire), prehospital providers (e.g., emergency medical technicians and paramedics), communications specialists, physicians, nurses, hospital administrators, and planners. Each State should provide a comprehensive statewide plan for assuring a stable EMS workforce including consistent EMS training and recruitment/retention programs with effective local and regional support. The State agency should:

- Ensure sufficient availability of adequately trained and appropriately licensed EMS personnel to support the EMS system configuration;
- Assure an ongoing state EMS personnel needs assessment that identifies areas of personnel shortage, tracks statewide trends in personnel utilization and which establishes, in coordination with local agencies, a recruiting and retention plan/program;
- Establish EMT as the state minimum level of licensure for all transporting EMS personnel;
- Routinely monitor training programs to ensure uniformity, quality control and medical direction;
- Use standardized education standards throughout the State that are consistent with the National EMS Education Standards;
- Ensure availability of continuing education programs, including requirements for pediatric emergency education;
- Require instructors to meet State requirements;
- Assure statutory authority, rules and regulations to support a system of EMS personnel licensure that meets or exceeds the national EMS Scope of Practice Model, new National EMS Education Standards, as they are available, and other aspects of the EMS Education Agenda for the Future; and
- Monitor and ensure the health and safety of all EMS personnel.

Status

The Florida Department of Health is statutorily responsible for the approval of EMS education programs and certification requirements of EMS personnel. With 66,244 certified EMS providers, the workforce appears to be sufficient, although gaps in some rural communities may exist. National testing is required for the initial certification of Emergency Medical Technicians (EMTs). But, for Paramedic initial certification examination or reciprocity a state examination is required and the national certification is not recognized. As one of only a few states that do not recognize national certification as an essential component of the personnel credentialing process, issues of reciprocity, disaster response capabilities and state level examination validation arise. This is inconsistent with the *EMS Education Agenda for the Future* and may be a barrier to the successful recruitment and retention of high quality Paramedics in Florida's system.

Statute and regulatory changes have been implemented to transition to the *National Scope of Practice Model* recommendations. However, references to the old National Standard Curricula remain in place to facilitate this transition. This process is expected to be completed by 2016. The EMS Section explored the need to establish certification requirements for Emergency Medical Responders (EMR) and Advanced Emergency Medical Technician (AEMT) and concluded it was unnecessary.

At the present time, no requirement for the accreditation of Paramedic training programs exists in rule or statute. However, the EMS Section, EMS Advisory Council and the majority of educators are supportive of the concept, with 39 of the state's 57 paramedic training programs having either achieved national accreditation or actively in the process of doing so. It is expected that those Paramedic programs not choosing to seek accreditation will either dwindle over time or attempt to provide courses that will only meet Florida Paramedic certification requirements but not meet national certification requirements.

The EMS Section is responsible for the review and approval of continuing education (CE) courses. Local medical directors are responsible for selecting the CE topics and approving them at the local level for recertification purposes. However, state rule requires that all certified EMS providers document no less than two hours of pediatric CE during each recertification period.

State oversight of EMS education is accomplished by a single staff member in the EMS Section with testing responsibilities resting with another program within the Department of Health. Although woefully understaffed, the EMS program has managed to support an EMS education system that may provide sufficient workforce resources to support the state's EMS personnel needs. However, there are insufficient resources to support ongoing oversight and monitoring the quality of the state's EMS education programs. There is limited opportunity for the EMS Section to engage in planning activities around

the future development of education programs as well as establishing quality standards and monitoring the state's existing EMS education programs. The EMS Section does routinely survey all EMS providers at the time of their recertification and the results of these surveys are reviewed and recorded. There is little opportunity with the current resources to develop workforce health and safety initiatives at the state level.

Recommendations

The Department of Health should:

- **Provide additional staff support to the EMS education program presently in place. No less than two additional EMS education professionals should be added to support current regulatory activities as well as establishing oversight and monitoring programs to support the state's EMS education programs and workforce.**

- **Promulgate regulations requiring the national certification examination as a basis for initial Paramedic certification.**

- **Promulgate regulations requiring national accreditation of all Paramedic education programs.**

- Complete full implementation of the *National EMS Education Standards* and adoption of the *National EMS Education Agenda for the Future*.

- Convene a work group to explore potential ways of assessing and monitoring the general health, safety and welfare of the state's EMS professionals.

D. TRANSPORTATION

Standard

Each State should require safe, reliable EMS transportation. States should:

- Develop statewide EMS transportation plans, including the identification of specific EMS service areas and integration with regionalized, accountable systems of emergency care;
- Implement regulations that establish regionalized, accountable systems of emergency care and which provide for the systematic delivery of patients to the most appropriate specialty care facilities, including use of the most recent Trauma Field Triage Criteria of the American College of Surgeons/Committee on Trauma;
- Develop routine, standardized methods for inspection and licensing of all emergency medical transport services and vehicles, including assuring essential pediatric equipment and supplies;
- Establish a minimum number of personnel at the desired level of licensure on each response and delineate other system configuration requirements if appropriate;
- Assure coordination all emergency transports within the EMS system, including public, private, or specialty (air and ground) transport and including center(s) for regional or statewide EMS transportation coordination and medical direction if appropriate; and
- Develop regulations to ensure ambulance drivers are properly trained and licensed.

Status

Florida has many challenges in providing a coordinated EMS transportation system. The land mass is one of the largest in the country with a population of nearly 19 million residents. The inherent beauty and recreational opportunities of Florida attract nearly 91 million visitors a year.

Though there is not a "statewide" EMS transportation plan, each of the 67 counties has the responsibility to ensure EMS is provided within the county. The county has the authority to establish guidelines for the issuance a Certificate of Public Convenience and Necessity (COPCN). This certificate must be obtained in order to be licensed by the Florida EMS Section to transport patients. This COPCN is needed for both ground and air ambulances.

Florida is served by 274 licensed EMS agencies. Of those, 173 are advanced life support (ALS) transport, 59 ALS non-transport, 8 basic life support (BLS) transport and 34 air ambulance services. There are approximately 4,231 permitted vehicles and 125 permitted aircraft. The EMS Section has sufficient authority to conduct inspections on these vehicles. However, they do not have sufficient staff to support the number of inspections that need to be done. The EMS section averages 130 agency inspections a year and the inspections are done on a random and unannounced basis.

Though the state has established minimum staffing and equipment standards, the equipment list has not been updated in over a decade. There is also a concern that pediatric equipment may not be readily available on all ambulances.

There are minimum staffing requirements for the BLS, ALS and Interfacility transport services. The BLS ambulance must have two staff, one of which is a certified EMT (at a minimum) and one ambulance driver. An ALS ambulance is also required to have two staff on board, one of which is a certified EMT (at a minimum) and one paramedic. Air ambulances must staff the aircraft with a minimum of one paramedic. Neonatal transports require two persons, one of which is an RN.

The state has also established minimum requirements and standards for ambulance drivers. The licensee must ensure the driver is at least 18 years of age, certified in CPR and first aid, hold a valid drivers license and is trained in the safe operation of emergency vehicles.

Though the state has the authority to adopt and enforce rules for interfacility transfers, there appear to be numerous challenges in administering the rules. There is variability within county guidelines for issuing COPCN for interfacility transport services. Rural areas have a difficult time meeting the staffing and equipment requirements. There are no guidelines to help decisions about when patients are appropriate to be transported by ground versus air ambulance. Finally, it was reported that neonatal teams and transports are not monitored and inconsistencies exist between services.

Recommendations

The Department of Health should:

- **Secure funding to hire adequate staff to conduct annual or biannual inspections of all permitted vehicles.**

- Consider establishing a regional system of ambulance inspections.

The EMS Section should:

- Review and update the standard equipment lists for ambulance services utilizing appropriate committees and medical directors.

- **Establish minimum staffing and equipment standards for specialty care transport with medical director and provider input.**

- Establish a standard guideline for ground versus air transport for specialty care patients.

- Utilize funds through the EMSC program and EMS grants program, to enhance provider capabilities to carry appropriate equipment to meet pediatric patient needs.

E. FACILITIES

Standard

It is imperative that the seriously injured (or ill) patient be delivered in a timely manner to the closest appropriate facility. Each State should ensure that:

- Both stabilization and definitive care needs of the patient are considered;
- There is a statewide and medically accountable regional system, including protocols and medical direction, for the transport of patients to state-designated specialty care centers;
- There is state designation of specialty medical facilities (e.g. trauma, burns, pediatric, cardiac) and that the designation is free of non-medical considerations and the designations of the facilities are clearly understood by medical direction and prehospital personnel;
- Hospital resource capabilities (facility designation), including ability to stabilize and manage pediatric emergencies, are known in advance, so that appropriate primary and secondary transport decisions can be made by the EMS providers and medical direction;
- Agreements are made between facilities to ensure that patients, including pediatric patients, receive treatment at the closest, most appropriate facility, including facilities in other states or counties;
- Hospital diversion policies are developed and utilized to match system resources with patient needs – standards are clearly identified for placing a facility on bypass or diverting an ambulance to appropriate facilities.

Status

The responsibility for licensure of hospitals/healthcare facilities in Florida lies with the Agency for Health Care Administration (AHCA). The basic license of each hospital may be augmented by additional designation in the following six specialty areas: Burn Unit, Primary Stroke Center, Comprehensive Stroke Center, Diagnostic Inpatient Cardiac Catheterization, Level 1 Adult Cardiovascular Services and Level 2 Adult Cardiovascular Services. Additionally, Florida statute recognizes trauma center designation for Level 1 and Level 2 Trauma Centers. AHCA maintains a database of all licensed facilities along with their specialty designations that is available for reference by EMS agencies. Each facility, through its CEO, is required to certify the availability of all services on an annual basis. There is no indication that this designation process is influenced by non-medical factors.

The ACHA database is not flexible enough to provide timely information for clinical decision-making. Other available software solutions may provide greater flexibility for matching patient needs to facility capability that could enhance transport decisions.

Destination criteria are established for trauma patients and stroke patients but are not defined for STEMI, Acute Coronary Syndrome or other patient categories, including pediatrics. These destination criteria have been established at the state level and destination protocols exist in a few local areas but regional protocols with associated medical accountability and oversight are not formalized across the state.

The Trauma System Consultation report (Feb 2013) identified similar concerns about integration among/between EMS agencies and facilities across the state. In part this reported stated "On a day-to-day basis, the trauma system functions as a loose aggregation of trauma centers, with little cooperation between trauma centers and almost no central coordination of EMS or trauma center activity". The reports and documents submitted in the course of this NHTSA technical assistance visit suggest that this finding extends broadly throughout the EMS system.

Some agencies do not recognize diversion status for healthcare facilities, although it is not clear this is a collaborative decision including EMS agencies and hospitals. In general, the EMS Section indicates that diversion and bypass policies that could be utilized by EMS agencies to match system resources to patient needs have not been developed.

Recommendations

The Bureau of Emergency Medical Oversight should:

- Continue to develop databases that improve the timeliness of information identifying hospital capabilities and facilitate access by local and regional EMS providers.
- **Continue to develop destination criteria with multi-level (state, regional, local) considerations.**
- **Ensure medical oversight and accountability for development of destination criteria as well as impact to resulting patient outcomes.**
- Incorporate collaboratively developed diversion and bypass policies at the regional and local level that are designed to match system resources with patient needs.

F. COMMUNICATIONS

Standard

An effective communications system is essential to EMS operations and provides the means by which emergency resources can be accessed, mobilized, managed, and coordinated. Each State should assure a comprehensive communication system to:

- Begin with the universal system access number 911;
- Strive for quick implementation of both wire line and wireless enhanced 911 services which make possible, among other features, the automatic identification of the caller's number and physical location;
- Strive to auto-populate prehospital patient care report (NEMSIS compliant) with all relevant times from the public safety answering point (PSAP);
- Provide for emergency medical dispatch training and certification for all 911 call takers and EMS dispatcher;
- Provide for priority medical dispatch;
- Provide for an interoperable system that enables communications from dispatch to ambulance, ambulance to ambulance, ambulance to hospital, hospital to hospital and ambulance to public safety communications;
- Provide for prioritized dispatch of EMS and other public safety resources;
- Ensure that the receiving facility is ready and able to accept the patient;
- Provide for dispatcher training and certification standards;
- The statewide communications plan includes effective, reliable interoperable communications systems among EMS, 911, emergency management, public safety, public health and health care agencies; and
- Each State should develop a statewide communications plan that defines State government roles in EMS system communications.

Status

Early on in its development of the communication system, Florida established 911 as the Universal Emergency Number. All counties in Florida are maintaining operational Enhanced 911. There is a 911 Board that coordinates the development of the system throughout the state.

Florida is to be commended for the development of a comprehensive EMS communications plan; Volume I and II established the statewide and regional communications system. The plan establishes reliable communications for day- to-day operations and mutual aid. There is a statewide scene coordination channel that has been designated for the "talk around" channel associated with MED-8. Talk around channels are governed by the respective communication plan for the 700 MHz interoperability and the 800 MHz mutual aid channels.

The main mode of communications for EMS is the radio system. EMS communications usually requires a "triangle" of coordination between the dispatch centers, EMS providers and hospitals. Statewide oversight and coordination for the communications system is provided by the 911 committee and Florida Department of Management Services.

A matter of concern for sustainability of the communications system revolves around the increased use of pay-per-use wireless phones by Florida residents. These phones do not have a zip code so a 911 fee cannot be assessed, resulting in decreased revenues for the system. Consumers are also dropping their land line capabilities which is further decreasing the 911 revenues.

There have been many enhancements made to the communications system. The phase 1 and 2 enhancements were minor adjustments. However, it is anticipated that the Next Generation 911 will require significant technology purchases especially when such capabilities as video streaming are desired.

With regard to dispatch centers and personnel, the state was tasked to develop dispatcher call taker training and certification standards four years ago. The Department of Education developed the training which includes a basic framework of 232 hours. The framework is revised and updated every three years.

When the Public Safety Telecommunicator (PST) training began in 2008, it was voluntary and over 1,400 personnel were certified. By 2010, the training became mandatory resulting in over 8,000 certified personnel. The PST are certified for a two year period and have to maintain 20 hours of continuing medical education.

Florida has a requirement for all 911 public safety telecommunicators to be trained and certified. However, there are no requirements for PSAPs to utilize priority dispatch systems when taking calls from the public. It is not known how many PSAPs are utilizing medical protocol dispatch systems. In addition, there appears to be little state or local medical direction oversight for EMS dispatchers and systems.

The state developed a comprehensive system for interoperability of radios called the Florida Interoperability Network (FIN). Initially, the system was strong with up to 240 sites three years ago, but has steadily decreased to only160 sites today. The predominant cause for the continuing system degradation is a lack of funding. The

system was built on proprietary technology but future innovation should be P25 compliant.

Recommendations

The Bureau of Emergency Medical Oversight should:

- **Secure funding to support future enhancements and sustainability of the Florida Interoperability Network (FIN) and Next Generation 911.**

The EMS Section should:

- Collaborate with PSAPs to implement the auto population of dispatch data into the EMS data collection system.
- Ensure radio system operations training is readily available to all users.
- **Encourage PSAPs to work with local EMS medical directors for case reviews and quality assurance.**
- Continue efforts to develop electronic registration and testing capabilities for PST.
- Conduct an assessment of PSAPs to determine the extent to which medical dispatch systems are utilized for dispatching medical resources.

G. PUBLIC INFORMATION AND EDUCATION

Standard

Public awareness and education about the EMS system are essential to a high quality system. Each State should implement a public information and education (PI&E) plan to address:

- The components and capabilities of an EMS system;
- The public's role in the system;
- The public's ability to access the system;
- What to do in an emergency (e.g., bystander care training);
- Education on prevention issues (e.g., alcohol or other drugs, occupant protection, speeding, motorcycle and bicycle safety);
- The EMS providers' role in injury prevention and control; and
- The need for dedicated staff and resources for PI&E.

Status

Through funding from CDC and EMS for Children (EMS-C) program, the Injury Prevention Office of the DOH regularly assesses the impact of injuries on Florida's residents. There is a wealth of data available for injury surveillance. Besides EMS and trauma data, the staff review death certificates, ED data, hospital discharge data and crash records. The data indicate that injuries are the leading cause of death among Florida residents ages 1-44; while drowning is the leading cause of death among children ages 1-4. Motor vehicles crashes, poisonings, and firearms injuries are the leading causes of injury deaths.

Between the Injury Prevention Office and the EMS Section, there are comprehensive strategic plans addressing public education and injury prevention throughout the state. The State EMS Advisory Council created a Public Information and Education Relations (PIER) committee that works with constituent groups to better understand education and injury prevention needs.

Florida has a robust injury prevention program within the Department of Health. The Office of Injury Prevention is involved with the PIER activities and both organizations support strategic planning. There are many excellent examples of programs and activities such as: "Prom Promise" and a distracted driving CD; falls prevention awareness training at the Clincon; participation with the Florida Department of

Transportation and the Motorcycle Safety and Pedestrian coalitions; National EMS Week campaigns; bike helmet training; pool safety programs; and administration of the Injury Prevention 101 course for EMS providers.

The EMS-C program is very active and involved with injury prevention and education activities as well. This program resides within the EMS Section. There are 41 counties that have Safe Kids coalitions. Florida recently completed the national readiness survey of hospitals to determine their capabilities to manage pediatric patients. Florida's readiness score was one of the highest in the country. They have a very active EMS-C Advisory Committee as well, that helps to direct planning, injury prevention and education efforts statewide. At the Preconference Clincon 2012, the EMS-C program conducted "Transporting non-critically injured children safely in an ambulance/rescue" course.

Many trauma centers are targeting injury prevention programs in their communities. The state trauma program has compiled a list of injury prevention programs and posted them on its website. However, in a recent survey, only 29 of the 274 EMS agencies have reported involvement with any injury prevention activities.

Recommendations

The EMS Section should:

- Continue to seek funding and opportunities to participate in targeted media efforts to educate the public on the emergency healthcare system and provide injury prevention programs.

- **Encourage more EMS agencies to engage in injury prevention and public education activities.**

H. MEDICAL DIRECTION

Standard

Physician involvement in all aspects of the patient care system is critical for effective EMS operations. EMS is a medical care system in which physicians oversee non-physician providers who manage patient care outside the traditional confines of the office or hospital. States should require physicians to be involved in all aspects of the patient care system, including:

- A state EMS Medical Director who is involved with statewide EMS planning, overseeing the development and modification of prehospital treatment protocols, statewide EMS quality improvement programs, scope of practice and medical aspects of EMS provider licensing/disciplinary actions;
- Online and off-line medical direction for the provision of all emergency care including pediatric medical direction, when needed and the authority to prevent and EMS provider from functioning based on patient care considerations; and
- Audit and evaluation of patient care as it relates to patient outcome, appropriateness of training programs and quality improvement.

Status

Medical direction of Florida's EMS system is among its strengths. At the same time it is one of its most prominent sources of potential undesired variation. Statute directs each EMS agency to maintain a relationship with a medical director who subsequently provides the authority for each EMT and paramedic to deliver clinical care. Beyond having a Florida medical license, there are no specific required qualifications for EMS medical directors. Statute details their responsibilities as relating to developing and monitoring standing orders and protocols, implementing and overseeing patient care quality assurance systems, ensuring security procedures for medications, and ensuring adherence to procedures to handle medications by EMS providers.

There are 179 EMS medical directors for Florida's 274 licensed EMS agencies. Thus, there are cases where a medical director may be responsible for multiple agencies and agencies in more than one county. Particularly in rural areas, willing potential EMS medical directors may be difficult to identify.

The state's EMS medical directors enjoy great latitude in determining the scope of care provided by their respective agencies. There are no statewide EMS protocols, nor is there specific direction as to what local protocols are required or issues they should address. While most EMS protocols are grossly similar, there is no mechanism to validate the necessity or appropriateness of variations when they do exist.

The Florida Association of EMS Medical Directors (FAEMSMD) provides one forum through which EMS medical directors may communicate with one another to share information and ideas. The FAEMSMD represents EMS medical directors on the Emergency Medical Services Advisory Council. Further, it is thought to be an important conduit for applying peer pressure among EMS medical directors, helping to ensure that EMS practice in Florida advances uniformly. However, although the FAEMSMD meets quarterly, less than 50% of EMS medical directors actively participate.

There is not a specific effort or plan within the Bureau of Emergency Medical Oversight to cultivate EMS medical directors throughout the state. Additionally, although EMS medical direction is desirable in communications centers providing emergency medical dispatch, there is not widespread inclusion. There, is, however, palpable progress in this regard as public safety telecommunicators have been required to be certified.

The State EMS Medical Director serves in a consultative and advisory role to the Department of Health. The position represents approximately 40% of a full-time equivalent effort. It is filled through a contract between the Department and the FAEMSMD. The current State EMS Medical Director was selected by the FAEMSMD by a vote of its members. The position has benefited from great stability over numerous years. The State EMS Medical Director is widely admired for his qualifications and collaborative leadership style.

The State EMS Medical Director is not, however, mentioned in statute. Thus, it is possible that a future leadership change or other pressures within the Department or the Division of Emergency Preparedness and Community Support could lead to position elimination for myriad reasons. Furthermore, the State EMS Medical Director has no statutory authorities or responsibilities. For example, he or she has no authority over local EMS medical directors or responsibilities for them, particularly in terms of ensuring their qualifications and quality of their work. Additionally, there are no provisions for him or her to ensure appropriate EMS medical direction during disaster situations that involve re-deployment of EMS providers.

Recommendations

The Legislature should:

- Provide authority for the Department of Health to establish initial and recurring qualifications for EMS medical directors beyond the requirement to be a licensed physician.

The Department of Health should:

- Codify the position of State EMS Medical Director clarifying responsibilities and authorities.

- **Establish initial and recurring qualifications for EMS medical directors beyond the requirement to be a licensed physician, including, for example, a degree of active participation within the FAEMSMD.**

- Conduct an evaluation of EMS medical director needs and resources within the State to help ensure optimal availability of physician expertise where needed.

The State EMS Medical Director should:

- Develop a forum to document and evaluate the appropriateness of variation when it is identified within EMS agencies' protocols.

The EMS Section should:

- Promulgate guidelines, in collaboration with FAEMSMD, for protocol and standing order development, including, for example, transportation destinations for specific patient populations within the spectrum of EMS systems' communities.

I. TRAUMA SYSTEMS

Standard

Each State should maintain a fully functional trauma system to provide a high quality, effective patient care system. States should implement legislation requiring the development of a trauma system, including:

- Trauma center designation, using American College of Surgeons Committee on Trauma guidelines as a minimum;
- Trauma field triage and transfer standards for trauma patients;
- Data collection and trauma registry definitions for quality assurance, using American College of Surgeons Committee on Trauma National Trauma Data Standards, as soon as practicable;
- Systems management and quality assurance; and
- Statewide Trauma System Plan, consistent with the Health Resources and Services Administration Model Trauma System Planning & Evaluation Document.

Status

Florida has demonstrated a clear commitment to the care of the injured patient as far back as the early1980s, resulting in a long history of trauma leadership at the national level. Legislative establishment of 19 trauma service areas (TSA) in Florida, with the subsequent development of sporadically located multidisciplinary operational units called trauma agencies, formalized the trauma system and enhanced development of the overarching EMS system. However, administrative inertia over the past 10-15 years resulted in non-compliance with statutory mandates that directly led to a contentious atmosphere mired in legal wrangling over trauma center designation.

At the request of the Florida Surgeon General the Trauma Systems Evaluation and Planning Committee of the American College of Surgeons Committee on Trauma conducted a statewide trauma system consultation in February 2013. The full report has been reviewed by the technical assistance team. The recommendations from that visit received prompt attention at the highest levels of the system with immediate implementation of an action plan to meet the most important recommendations. Highlights of changes already effected since that visit include:

- Trauma Leadership
    - Administrative Program Director hired April 2013
    - Quality Improvement Coordinator hired July 2013

- Medical Director hired September 2013

- Performance Improvement
  - Statewide quality improvement coordinator hired

- Next Generation Trauma Registry
  - NGTR in test mode & will be ready for 1 Jan 2014

- EMS/National Highway Traffic Safety Reassessment
  - November 12-14

- Statutory Revision Ad Hoc Committee
  - Multi-disciplinary; committee began on October 29th report due in mid-January

Additionally, positive action has already been initiated for a large number of other recommendations from the report.

Recommendations

The Bureau of Emergency Medical Oversight should:

- **Embrace the recommendations of the Trauma System Consultation report by the ACS COT. We call specific attention to the following recommendation from that report:**
  - **Require that all acute care facilities participate in the inclusive and integrated trauma system as a condition of licensure.**
    - **Designate each acute care facility at an appropriate level, either as a trauma center or a participating facility.**
    - **Require all facilities to submit at least a minimal set of data on every injured patient to the state registry.**
- Continue efforts to develop a model inclusive trauma system.
- Encourage continued collaboration between the EMS and trauma programs.

J. EVALUATION

Standard

Each State should implement a comprehensive evaluation program to assess effectively and to improve a statewide EMS system. State and local EMS system managers should:

- Evaluate the effectiveness of services provided to victims of medical or trauma-related emergencies;
- Define the impact of the system on patient care and identify opportunities for system improvement;
- Evaluate resource utilization, scope of service, patient outcome, and effectiveness of operational policies, procedures, and protocols;
- Evaluate the operation of regional, accountable emergency care systems including whether the right patients are taken to the right hospital;
- Evaluate the effectiveness of prehospital treatment protocols, destination protocols and 911 protocols including opportunities for improvement;
- Require EMS operating organizations to collect NEMSIS compliant data to evaluate emergency care in terms of the frequency, category, and severity of conditions treated and the appropriateness of care provided; Assure protection from discoverability of EMS and trauma peer review data;
- Ensure data-gathering mechanism and system policies that provides for the linkage of data from different data sources through the use of common data elements;
- Ensure compatibility and interoperability of data among local, State and national data efforts including the National EMS Information System and participation in the National EMS Database;
- Evaluate both process and impact measures of injury prevention, and public information and education programs; and
- Participate in the State Traffic Records Coordinating Committee (TRCC) – a policy-level group that oversees the State's traffic records system, to develop and update a Statewide Traffic Records System Strategic Plan that ensures coordination of efforts and sharing of data among various State safety data systems, including EMS and Trauma Registry data.

Status

Efforts to conduct meaningful evaluation of Florida's EMS system occur principally at local levels. There, EMS medical directors are charged to establish a quality assurance committee to provide for quality assurance review of all emergency medical technicians and paramedics operating under their supervision. Currently, individual agencies must maintain their own information systems to facilitate evaluations of EMS operations and clinical care.

The Department of Health requires every EMS agency to submit data that ostensibly supports statewide EMS system evaluation. Some, collectively providing care to approximately 25% of the state's EMS patients, submit aggregate data on a monthly basis. This amounts to summary information that is quite limited in terms of facilitating meaningful assessments of EMS operations and quality of care. For the other 75% of the state's EMS encounters, EMS agencies submit patient care records directly to EMSTARS, Florida's statewide EMS database. Submission of patient care records to EMSTARS is voluntary. Although the majority of cases are captured in EMSTARS, there are notable exclusions including most of Dade County. One issue inhibiting EMS agencies from submitting data to EMSTARS is their concern regarding adequacies of protections from legal discovery and release of subsequently developed information.

EMSTARS currently contains data for millions of EMS encounters. However, the abilities to query the database and provide meaningful feedback to EMS agencies are lagging. A few standard reports are available. Further, agencies and their medical directors are able to request specific queries, and do so occasionally. Many more requests would easily overwhelm the staff's capacity to fulfill them. There are active efforts to transition to NEMSIS version 3, which will augment Florida's abilities to someday make comparisons with nationally aggregated information.

The Emergency Medical Review Committee (EMRC), working closely with the Data Committee of the Emergency Medical Services Advisory Council, conducts system-wide evaluations. Using EMSTARS and other sources of health care and public safety data, EMRC conducts assessments of various aspects of the EMS system. To date, these have been fairly high level and are subsequently shared with EMS system stakeholders. Examples include evaluations of response time intervals. Examination of the prevalence of documentation of capnometry application among intubated patients led to an alert from the State EMS Medical Director.

Evaluation of the EMS system can be considered in three aspects. In increasing meaningfulness and complexity to assess, they are structures, processes, and outcomes. Structure, as the least dynamic, is the least challenging to evaluate. The EMS Section is aware of the EMS resources in Florida in a general way, including numbers of licensed personnel and vehicles. There is uncertainty about the level of detail known for some system features, including specialty transport services and hour-

by-hour availability of specific hospital-based emergency services.

Process measures can provide additional insight. The assumption is often made that improved processes, as determined by some objective measure, translate to improved outcomes. For example, shorter response times might lead one to believe that survival of certain conditions will be improved. Depending on the process and the outcome, the link may or may not be valid. EMSTARS has provided some ability to assess response intervals and frequencies of EMS calls. Some of these evaluations have led to sophisticated mapping using geographic information systems. The far-ranging multitude of additional potential process measures awaits further development on a statewide basis.

The more difficult challenge is to evaluate outcomes. On a statewide basis there is little ability to evaluate the effectiveness of the EMS system in terms of improving outcomes. However, there is considerable work ongoing to link EMS records with other sources of data that can be used to derive outcomes information.

Recommendations

- **The Legislature should clarify, in statute, the protections provided from legal discovery for the State's EMS database containing patient records and the quality information derived from it.**

- **The EMS Section should require all EMS agencies to submit patient care data to EMSTARS, potentially providing incentives and disincentives for participants and non-participants, respectively, through the EMS grants process.**

- The Division of Emergency Preparedness and Community Support should:

    - Ensure adequate funds and staff to fully develop Florida's EMS information system, including routine provision of agency specific information to those who generate it.
    - Ensure continuing development of data linkages that characterize the continuum of care and outcomes among EMS patients.

- The EMRC should develop agency-specific feedback, in the form of report cards for example, that can be obtained on-demand by individual EMS agencies.

K. PREPAREDNESS

Standard

EMS is a critical component in the systematic response to day-to-day emergencies as well as disasters. Building upon the day-to-day capabilities of the EMS system each State should ensure that EMS resources are effectively and appropriately dispatched and provide prehospital triage, treatment, transport, tracking of patients and documentation of care appropriate for the incident, while maintaining the capabilities of the EMS system for continued operations, including:

- Clearly defining the role of the State Office of EMS in preparedness planning and response including their relationship with the State's emergency management, public health and homeland security agencies;
- Establishing and exercising a means to allow EMS resources to be used across jurisdictions, both intrastate and interstate, using the Emergency Management Assistance Compact and the National Incident Management System;
- Identifying strategies to protect the EMS workforce and their families during a disaster;
- Written protocols, approved by medical control, for EMS assessment, triage, transport and tracking of patients during a disaster;
- A current statewide EMS pandemic influenza plan; and
- Clearly defining the role of emergency medical services in public health surveillance and response.

Status

The Florida peninsula has long been vulnerable to natural disasters such as hurricanes. This risk, coupled with the events of 9/11, has led the state to be proactive in overall disaster preparedness planning. Florida is the recipient of two federal funding streams, Public Health Preparedness (PHEP), and Assistant Secretary for Preparedness and Response (ASPR) totaling 145 million dollars over the last three years. These funds have enabled the state to support public health and hospital disaster preparation and resulted in Florida's recognition as a leader in healthcare preparedness efforts.

Of course money alone does not resolve all the many issues associated with disaster response. Strong leadership also plays a major role in the successes of this program. The Responder Safety and Health Program within the Bureau of Preparedness and Response and EMS Section have shown the willingness to collaborate with a variety of

stakeholders from a number of disciplines that has also contributed to the successful development and implementation of the system components now in place.

The ACS/COT conducted a Trauma Systems Consultation visit in February of this year and several of the issues discussed and recommended have already been implemented. An example is the statewide implementation of EMresource and HavBed to include acute care hospitals, EMS agencies, and dispatch agencies. In addition, the development of an ambulance deployment plan is now in place. This plan like most disaster plans is a working document that will continue to be revised and address issues associated with the deployment of ambulances to disaster areas as needed.

One issue currently being discussed by the EMS Advisory Council's Disaster Committee is the methodology to provide medical oversight to the EMS personnel operating outside their jurisdiction. Since EMS personnel are certified as opposed to licensure and working under the direction of a local medical director it is necessary to continue efforts to address this issue to avoid inconsistencies and confusion in a disaster situation.

A Healthcare Coalition workgroup has been formed and are discussing ways of bringing additional healthcare partners into the system. This is an effort mandated by the ASPR program to shift funding from hospitals to a more broad representation of statewide healthcare providers. Although this effort is challenging for all states Florida is making good progress in establishing the coalitions.

One issue of concern is the future support of the Florida Interoperability Network (FIN). Interoperability among responders has been a major concern in all previous disasters throughout the country in recent years. It is imperative that funding be identified and stakeholder support obtained to not only provide support for the current functionality of the system but aggressive efforts implemented to obtain long term sustainability.

Recommendations

The Department of Health should:

- Continue to develop a methodology to provide medical oversight to the EMS personnel operating outside their jurisdiction.

- **Encourage all EMS providers to maximize the use of the EMresource and HavBed tools for day to day operations of EMS and not just during a disaster.**

- Continue efforts to develop Healthcare Coalitions within the seven Regional Domestic Security Task Force Regions as recommended in the ACS Consultation Report.

- Identify funding and gain stakeholder support to provide long term sustainability for the FIN system.

L. CURRICULUM VITAE

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  EMS Agenda for the Future
  EMS Agenda for the Future Implementation Guide
North Carolina Office of EMS
  State Trauma Advisory Committee
  Trauma Center Site Reviewer
Pitt County, NC, Emergency Management
  EMS Oversight Committee
DOT/NHTSA, EMS Assessment Program, TAT, Member,
  State of South Carolina
DOT/ NHTSA EMS Reassessment Program, TAT, Member, States of Colorado,
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American College of Surgeons Committee on Trauma
  Trauma Systems Consultation Committee (IN, TX)
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ORGANIZATIONS/APPOINTMENTS

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Trauma Systems Evaluation and Planning Committee, COT
Performance Improvement and Patient Safety Committee, COT
Tactical Combat Casualty Care Committee
Trauma Outcomes and Performance Improvement Course (TOPIC) Former Instructor
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Cape Fear Valley Health System Fayetteville, NC, Director of Surgical Critical Care, Former Trauma Medical Director,
Walter Reed Army Medical Center, Former Chief, Trauma Section, General Surgery Service
Former, Trauma Consultant to the Surgeon General of the Army
Landstuhl Regional Medical Center Germany, Former Chief, Division of Surgery, Former, Director, Trauma Program
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Womack Army Medical Center,Fort Bragg, NC, Former, Chief, Department of Surgery
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Colorado Emergency Medical and Trauma Services Section, Colorado Department of Public Health and Environment, Chief
National Association of State EMS Officials (NASEMSO), President, 2010 – 2012.
Committee on the Accreditation of Education Programs for the EMS Professions (CoAEMSP) 2006-2010, Past Chairman
Pueblo Community College, Department Chairman
State of New Mexico Emergency Medical Services Bureau, State EMS Training Coordinator/EMS Program Operations Manager
National Council of State EMS Training Coordinators, Inc., Chairman
US Department of Transportation, Paramedic Curriculum (1986) Leadership and Development Committee
Injury Prevention Program for EMS Providers, Leadership and Development Committees
States of Colorado and New Mexico, Legislative Policy Development and Implementation
Colorado and New Mexico Statewide EMS Advisory Councils
Colorado statewide EMS and Trauma Advisory Council, Executive Secretary
New Mexico EMS Statewide Advisory Committee, Former Vice Chairman
Emergency Medical Technician and Paramedic, Las Cruces, New Mexico
1990- New Mexico Governor's Award
1998-Colorado EMS Instructor of the Year
2006-Colorado EMS Association President's Award
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National Association of State EMS Directors (1979-1996)
  Past President
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American Trauma Society
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  Committee Studying Use of Heimlich Maneuver on Near Drowning Victims, Member
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North Carolina Hospital Preparedness Committee, Former Chairman
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Executive Support, On-Site Project Management, Technical Document Editing.

- In addition to Emergency Medical Services Reassessments, she has worked with teams nationally that assess state highway safety programs that include Impaired Driving, Occupant Protection, Motorcycle Safety, Pedestrian Safety, and Driver Education.

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NASEMSO liaison for the ACS Trauma System Planning and Evaluation Executive Committee
NHTSA EMT Refresher Course Curriculum Development
HRSA Rural Trauma Grant Reviewer
Utah Public Health Association, Member
American Trauma Society, Member
Task Force Chair for Utah Trauma System Development
Air Ambulance Rules Task Force, Chair
Appointed to Governor's Council on Blood Services
Previous member of State EMS Training Coordinators Council
CLEAR Certified Inspector
Utah Emergency Managers Association, Member
Certified EMT-I, 1983.
ACS, State Trauma System Assessment, Team Member, States of Alaska, Minnesota, Colorado, Louisiana, Texas and Florida.
USDOT, NHTSA, EMS Reassessment Program, Technical Assistance Team, Member, States of Michigan, Oklahoma, Delaware, Missouri, Ohio, Wisconsin and Wyoming and Connecticut.
IOM Crisis Standards of Care Committee, Member
Planning Committees member for IOM Rural EMS Workshop and Panel Discussion Chair.