



State EMS Structure

The EMS Funding Task Force heard testimony regarding the roles and responsibilities of resource hospitals during multiple public meetings. Although comments about resource hospitals varied from meeting to meeting one thing became clear.....*No EMS system or resource hospital is the same.* For many years the term “EMS Kingdoms” has been used to describe the typical EMS Resource hospital in Illinois. Unfortunately, this separation from area to area with liberal control being given to each “King” has led to some inaccurate and inconsistent theories and practices. Furthermore this has contributed to the current fragmented condition of Illinois’ EMS.

To determine the direction we need to go, we must understand where we have already been and where we currently stand. The Emergency Medical Systems Act has identified the Illinois Department of Public Health as “the *central authority* responsible for the coordination and integration of all activities within the state concerning pre-hospital and inter-hospital emergency medical services.” (210 ILCS 50/2 Sec 2) This same act states that the Department “shall designate Emergency Medical Services (EMS) *Regions* within the state, consisting of specific geographic area encompassing EMS systems and trauma centers.” (210 ILCS 50/3.15) The EMS Act further defines the EMS System and its role and function as “pursuant to the EMS Region Plan adopted for the EMS Region in which the System is located.” This Act gives us *three* levels of authority in regards to the governing of EMS in this state with IDPH being the highest and *Central Authority*.

Although IDPH has been given the authority over All activities, the Regions (through a Medical Directors committee) (210 ILCS 50/3.30) have the following role: 1. Protocols for inter-system/inter-region patient transports; 2. Regional Standing Medical Orders; 3. Patient transfer patterns; 4. Protocols for resolving regional or inter-system conflict; 5. A regional EMS disaster plan; 6. Regional standardization of continuing education requirements; 7. Regional standardization of DNR policies; 8. Protocols for disbursement of department grants. There is regional Advisory Committee to advise the Region’s EMS Medical Directors committee and to select a representative to serve on the state EMS Advisory Council.

The EMS System in Illinois functions as the lowest level of the state organizational structure. The System operates, under Regional plans and protocols. The system is given 18 specific duties through the EMS Act. (210 ILCS 50/3.35) Because these duties are too numerous to list in this article, and because there was a fair amount of testimony at some of the task force meetings, specifically regarding licensure, education and investigations, this article will clarify some misconceptions about the responsibilities of “The System” or Resource hospital.

First, the *System* does NOT license. The System’s role is to notify IDPH of personnel who have successfully completed requirements as established by the state. This does not prohibit individuals from licensing independently if they are not affiliated with a

System. Furthermore, an ILS or ALS system may even require its EMTB personnel to apply directly to the IDPH for determination of re-licensure. Second, Education or *coordinating* the education of various levels of pre-hospital provider is generally provided through a system. This appears to be accurate although it does not exclude the system from working with any or all educational facilities and/or instructors to promote the availability of classes. The opposite is true when some systems have tried to block or monopolize availability of training but final approval for ALL classes remains under IDPH authority. Finally, no specific investigative responsibility is given to the Resource Hospital or System. Ultimately, the system itself must “Operate in compliance with the *EMS Regional Plan.*”

Various people testified at the task force meetings that the expense of operating a Resource System Hospital is a burden to many hospitals. Because the coordination of education can be costly, especially to the rural volunteer agencies, many Systems/Resource hospitals charge for required classes. This cost many times is passed on to the volunteer services struggling to maintain staffing requirements and increasing educational demands placed on them by the System. As the educational requirements increase, so does the cost. However, at least one college testified that they can provide quality training at a cheaper price than many Resource Hospitals. A solely educational industry such as a college may even provide more funding opportunities and advanced delivery options (including online or network classes) for the individual or volunteer organization. It may also help with the EMT-Intermediate issue which we will not discuss in this article.

In considering the expense of running an EMS system one should consider the fact that a nongovernmental industry (hospital) has been given governmental authority as the “right arm” of IDPH. At times this may lead to conflicts of interest when a hospital is given authority over public, private and governmental pre-hospital entities and sometimes even competing services. This present structure is the basis of “EMS Kingdoms.” It fragments regional and statewide EMS delivery. Lawmakers should be careful as state EMS funds are distributed. Because of Illinois’ financial problems, the financial burden in administering Emergency Medical Services has been passed on to the Resource Hospital level of the state EMS organizational structure. With that, a fair amount of authority seems to have been passed along also. State authority must remain with state agencies and only given to industries and individuals without conflicts of interest that can ultimately fulfill the goal of maintaining adequate EMS services in this state.

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