

NATIONAL EMS PROGRAM STAFF'S PERSPECTIVE OF EMERGENCY MEDICAL SERVICES IN INDIAN HEALTH SERVICE

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BACKGROUND

In 1965, the PRESIDENT'S COMMITTEE FOR HIGHWAY SAFETY recommended a national program to aid those injured in highway crashes. The report set forth guidelines for a definitive emergency medical response system on a Nation-wide basis.

The now famous "WHITE PAPER" of 1966 focused national attention on the unnecessary loss of life and injuries due to accidents and labeled it the neglected disease of modern society. Some of the conditions existing in the mid-sixties that these reports documented included:

1. Few of the emergency medical care workers (pre-hospital and hospital) were adequately trained, yet every person working in a high-risk industry (i.e. police, firemen, ambulance, etc.) should receive appropriate training.

2. There were no generally accepted standards to evaluate the competence or training of ambulance attendants. This pointed out the immediate need for a standardized course of instruction with suitable training aids.

3. Nearly half of the Nation's ambulances were provided by 12,000 morticians. The vehicles (hearses) were unsuitable for permitting active care during transportation. There were no acceptable standards for vehicle design.

4. Helicopter ambulances had not been adapted to civilian needs even though their worth had been proven in the Korean and Vietnam experiences.

5. Ambulance medical equipment and supplies were inadequate.

6. For the most part, ambulance radio installations provided communications only between dispatcher and driver.

7. The reports also indicated there was a critical need to provide affordable emergency medical care to rural areas"

This was the basic status of emergency medical care being provided throughout the Nation in 1966.

The emergency medical care being provided by IHS was even more basic and primarily consisted of GSA station wagons (with no radio communications) equipped with only a gurney or stretcher. Ambulance drivers/janitors had little or no first aid training, yet they routinely were required to respond to life threatening situations, often traveling alone at great distances with no medical supplies or equipment.

THE EARLY YEARS 1968-78

In 1968, Mr. John Emelio, then Chief, Administration Services Branch, Aberdeen Area IHS, initiated the first contract for emergency response and transport services with the Rosebud Sioux Tribe. This contract was developed as a direct result of a multiple car accident in which 5 seriously injured patients were

"loaded" into an IHS ambulance (station wagon) and transported to the Rosebud PHS Indian Hospital. One of the patients arrived at the hospital DOA and the subsequent autopsy report indicated that this patient had suffocated in the ride to the hospital and had not expired as a result of the injuries sustained in the car accident. Mr. Floyd Reynolds, an enrolled member of the Rosebud Sioux Tribe, had just returned from San Jose, California where he had been employed as an ambulance attendant and he became the first ambulance director of the Rosebud Sioux Tribal Ambulance Service. The Oglala Sioux Tribe contracted for similar services the following year.

Implementation of the EMS system Act of 1973, enabled Tribal governments to receive start up funding. However, very few Tribes took advantage of this opportunity because of a lack of EMS expertise within the Indian Health Service. In 1976 Dr. Emory Johnson, then IHS Director, appointed Mr. Emilio to provide leadership to the IHS EMS Program in Headquarters. Mr. Emilio immediately established a close working relationship with Dr. David Boyd, Director of the now defunct EMS Bureau, within DHHS. Dr. Boyd was nationally recognized as the EMS expert.

DEVELOPMENT AND MAINTENANCE YEARS 1978-90

In 1978 the Indian Health Service recognized that EMS was an ongoing and important part of the comprehensive health delivery system being provided for American Indian and Alaskan Natives with the issuance of Chapter 17 of the IHS Manual. This manual issuance set the roles and responsibilities for all disciplines/entities. During the years of 1978-80, Mr. Emilio started to staff the key positions of the National EMS team and named Dr. Tom Bonifield as EMS Research and Evaluation Consultant; Mr. Jerry Rousseau, EMS Training Coordinator; Mr. Pete Decker, EMS Vehicles and Communications Consultant; and Dr. Jack Porvaznik, EMS Medical Control Director. Area Directors also designated EMS Program Coordinators for each Area /Program Office. Mr. Emilio was instrumental in forming the IHS EMS Advisory Board.

The Board was comprised of Headquarters staff, Area Comes, EMS Coordinators, Nurse Consultants and several Tribal delegates. Dr. Boyd was a key member of the IHS EMS Advisory Board and provided valuable support and guidance. The Board established policy and set priorities.

There were no funds earmarked for EMS during the 1970's and monies used to support EMS activities were allocated at the discretion of the Area Directors.

Therefore, growth of EMS systems was usually the result of local initiatives (e.g. political pressure of Tribal councils).

During the FY-1980 congressional hearings, representatives from the National Indian Health Board, National Congress of American Indians, National Tribal Chairmen's Association and Association of American Indian Physicians testified that Tribal Governments and their communities placed a high priority on EMS response and transport programs for which there was a \$10 million unmet budgetary need. Based principally on the testimony of these Tribal leaders, Congress appropriated \$1 million for "expansion of emergency medical services." This appropriation in FY-1980 allowed for the provision of critical training for first responders, EMTs, ER Nurses and ER physicians. It also allowed for the development of Research and Evaluation documents, purchase of communications equipment, radios and supported other program expansion efforts.

In August of 1981, the National Tribal Chairmen's Association passed a unanimous resolution in support of a \$20 million funding requirement for effective operation of the EMS Program and requested a separate line item to assure the EMS needs of the American Indian and Alaskan Native peoples are equitably and adequately met.

In 1982-83, \$4 million was transferred from the CHR program to the EMS program. with the initial appropriation of \$1 million in FY- 80, these funding sources have allowed IHS and the Indian Tribes to operate successful EMS systems throughout the country. Since the 1970's, Emergency Medical Services has shown steady growth and expansion throughout Indian country, but without supplemental funding.

During development, the IHS EMS Program identified and utilized any available resources, such as:

1. EMSS Act planning monies and technical assistance.
2. GSA leased ambulances. Partial funding was provided annually from unobligated Headquarters and Area reserves.
3. Communications systems, networks, and equipment were provided by some states. Additional equipment was obtained through use of unobligated reserves.
4. Training was provided by DOT, states, teaching institutions, the American College of Surgeons, American Heart Association, and IHS Training Centers.
5. Operating funds and resources were obtained through tribal work programs (i.e. Comprehensive Employment Training Act [CETA), 3rd Party payments, Federal grants and IHS contracts.
6. Manpower was obtained through CETA workers, CHRs, volunteers and IHS contracts.

Many of the EMS program activities initiated during the developmental years of 1976-1984 are still functioning (e.g. acquisition of ambulances, establishment and maintenance of communication systems, and provision of quality training and continuing education). These program activities have been identified as the main "pressure points" vital to assure continuity of the program. The IHS EMS Program requires continuous attention to assure that it is maintained in a state of readiness, therefore, ambulances must be replaced immediately when "worn out," "wrecked" and when new program needs arise. Training must be provided on a continuous basis for pre-hospital and hospital based EMS personnel because of high turnover rates. Continuing education is essential to combat skill deterioration, etc. Standards evolve and change in this dynamic discipline and quality training for all EMS personnel is essential. Area program reviews (Quality Improvement) must be conducted on a regular basis to show signs of improvement.

IHS in special partnership with Indian Tribes have been systematically developing pre-hospital response and transport systems with properly equipped ambulances and certified EMTs, and improving the quality and capabilities of IHS

hospitals and emergency rooms in terms of staffing, training, and equipment. Some of these EMS systems in Indian country serve as success models for rural and underdeveloped countries. (Dr. Jack Porvaznik was detailed by DHHS to provide technical assistance to Saudi Arabia and Mr. Emelio assisted in providing technical assistance and consult to the country of Portugal).

In September of 1984, Mr. Gordon Jensen was designated the IHS EMS Program Coordinator. The National EMS Staff has assumed a greater role as technical consultants to Area Offices, Tribal Governments and IHS service units. By conducting Area program reviews the National EMS Staff have established a "state of the art" level of EMS system design and development that is available to every location in Indian country. The National EMS Staff are currently in the process of gathering and compiling data similar to data that was retrieved from the 1987 EMS Survey. Once these data are collected and analyzed, a quantitative justification for funding requests will be available. The National EMS Staff regularly interacts with the IHS community Injury Prevention and IHS Substance Abuse programs to coordinate approaches of mutual interest (e.g. reduction of DUI-related motor vehicle accidents).

CURRENT STATUS

Dr. Jack Porvaznik, EMS Medical Director since 1980, retired in late 1990. Since his retirement, the EMS Program has not received the attention that is necessary to function adequately.

Until then, resources were made available each year for the important functions such as:

1. provision of critical EMS training and continuing education for pre-hospital and hospital based personnel
2. acquisition of ambulances and patient care equipment, and
3. Quality Improvement activities (program reviews).

The following detrimental situations have developed recently:

1. For the first time in seven consecutive years, no year-end funds were allocated for the acquisition of ambulances despite a detailed analysis and documentation of the critical need.
2. No funds have been provided for EMS training activities. Several courses for which there is a clear and valid need have been canceled (i.e. , An all IHS Advanced Trauma Life Support Provider Course for 16 ER physicians and 16 ER Nurses, an EMT Basic Course for the Ute Mountain Ute Tribe, and several other requests are in danger of being canceled).
3. Travel has been restricted requiring approvals from higher echelons in IHS. Consequently, no Area program reviews (Quality Improvement) have been completed despite the requirement to conduct 3-4 Area reviews annually.
4. An IHS EMS Medical Director, replacing Dr. Porvaznik, has not yet been designated. It is a fundamental requirement that EMS medical direction and EMS medical control be assigned to a single individual and not rotated among several persons on an "ad hoc" basis.

DISCUSSION

No other IHS program has epitomized the special partnership existing between Tribes and IHS than EMS. The Tribal Governments have become the primary provider of emergency medical response and transport, employing over 700 EMTs and operating over 150 ambulances. It is easy to see why EMS has been called one of the most dynamic health care programs in Indian country. EMS continues to receive strong support from the Indian communities that are being served, and the loyalty, commitment and dedication of the entire EMS personnel (pre-hospital and hospital) is second to none.

Dramatic improvements in the health status of the Indian people have been well documented since the creation of the Indian Health Service in 1955 with spectacular decreases in infant death rates, deaths from gastroenteritis, and deaths from infectious diseases. The death rates from these major killers of Indian people are now comparable to those of the U.S. in general. However, death rates from accidents during this same period have remained consistently about three times the national averages, with many Indian reservations experiencing death rates from accidents at four or five times the national average. The very high accident death rate can be attributed primarily to motor vehicle accidents. Motor vehicle accidents (MVAs) are the leading cause of death and disability among Indian people and this statistic is even more shocking when we indicate that accident deaths are highest in the age group 15-45, the years we can designate as the "years of potential and the years of productivity". It can be stated with a high degree of certainty that a person who dies as a result of a motor vehicle accident will more than likely be a "breadwinner" and the impact upon the entire family unit will be catastrophic.

Though high, the morbidity and mortality rates for all types of accidents among American Indians and Alaskan Natives have been decreasing every year since the mid-1970's. Much of this success can be directly attributed to the unselfish commitment and dedication of the Tribal and IHS EMS programs whose missions are to respond and treat life threatening illness and injury.

Motor vehicle accidents remain the leading cause of death and disability among American Indian and Alaskan Natives, especially for those in their "prime" of life. A concerted, coordinated effort is needed by IHS and the tribes to reduce the effects of this epidemic which continues to claim a disproportionate number of American Indian and Alaskan Native lives each year.