Twenty Years of Emergency Medical Services for Children: A Cause for Celebration and a Call for Action

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ABBREVIATIONS. EMSC, Emergency Medical Services for Children; EMS, emergency medical services; AAP, American Academy of Pediatrics; PECARN, Pediatric Emergency Care Applied Research Network.

The 20th anniversary of the federal Emergency Medical Services for Children (EMSC) program should be cause for great celebration within the emergency medical services (EMS) community and for all child health care advocates. Over the past 20 years, the EMSC program has helped lead the way toward systematic improvements in the delivery of emergency care to children in every state in the United States. Contributions by the EMSC program have resulted in remarkable advances in pediatric emergency care and substantial improvements in the quality of life of countless ill and/or injured children. The EMSC program is undoubtedly responsible for saving many young lives.

A review of the EMSC program's accomplishments over these past 2 decades should stimulate a great sense of satisfaction, even pride, within our profession. Many practitioners who care for acutely ill or injured children have likely benefited from products developed by the EMSC program (eg, educational tools and training programs; pediatric medication and equipment standards; and pediatric emergency care protocols, practice guidelines, and facility preparedness standards).[1–3] Some of you may also be actively engaged in EMSC-sponsored activities within your institution, state, or professional organization. The sense of satisfaction and pride we have in the EMSC program's accomplishments are only exceeded by the anticipation of the advances in pediatric emergency medical care that lie directly ahead.

It is unfortunate that as we celebrate EMSC's 20th anniversary, current events threaten the program's future and should be a cause of great concern to all of us. The President's budget for fiscal year 2006, released on February 7, 2005, requested no funding for EMSC, effectively proposing to eliminate the program. In addition, the program's authorization is scheduled to expire at the end of this fiscal year. The future of EMSC, and the great promise it holds for additional advances in pediatric emergency care, now requires unified advocacy and action by all who care for acutely ill and injured children.

For those who are unfamiliar with EMSC (and with apologies to those who are well acquainted), a brief history is warranted. Our nation's EMS system was developed in response to observed deficiencies in the delivery of prehospital and hospital-based emergency care to patients with critical illness or injury, with adult cardiovascular disease and trauma representing the sentinel examples. The Emergency Medical Services Act of 1973 helped to create the foundation for today's EMS systems, stimulating improvements in the delivery of emergency care nationally. Despite those improvements, significant gaps remained evident in EMS care, particularly within the pediatric population.

These gaps were present because early efforts at improving EMS care did not appreciate that acutely ill and injured children could not be treated as "small adults." Children possess unique anatomic, physiologic, and developmental characteristics that create vitally important differences in the evaluation and management of many serious pediatric illnesses and injuries. Unique pediatric health care needs make it difficult for emergency care providers to provide optimal care in adult-oriented EMS systems (eg, personnel training, facility design, equipment, medications).

The recognition of a deficiency in pediatric emergency care ultimately prompted federal legislation and funding for the EMSC program in 1985. EMSC provided a productive multidisciplinary setting in which health department officials, EMS provider agencies, clinical leaders from professional societies, and key stakeholder groups came together with a shared mission to improve pediatric emergency care. Participants included members of organizations such as the American Academy of Pediatrics (AAP), American College of Emergency Physicians (ACEP), American College of Surgeons (ACS), Emergency Nurses Association (ENA), National Association of Children's Hospitals and Related Institutions (NACHRI), National Association of EMS Physicians (NAEMSP), National Association of State EMS Directors (NASEMSD), and the National Association of Emergency Medical Technicians (NAEMT), to name just a few. Within communities and states, and at a national level, these groups collaborated effectively to narrow the pediatric emergency care gap.

The first decade of EMSC was characterized by state-specific EMS needs assessments and demonstration grant projects. By the end of that decade,

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EMSC had made its way to every state, the District of Columbia, and the 5 US territories. This widespread support for pediatric issues by the EMSC program continues to the present day.

The EMSC program has assured that necessary attention would be given to pediatric emergency care concerns within each state's EMS office, raising the bar for pediatric emergency care. The EMSC program fosters collaboration both within and between states. This regional and national perspective has largely eliminated discrepancies in regulations among states, has resulted in the establishment of national norms for pediatric emergency care, and has made children's issues in emergency medical care a national priority.

The second decade of EMSC has seen continued improvement in the delivery of emergency care to children. In addition to partnerships with states and territories, EMSC has partnered on key program initiatives with numerous professional societies. EMSC has also provided funding support for the EMSC National Resource Center (www.ems-c.org), which provides the nation with educational and informational resources focused on improving the system of care for children. EMSC also supports the National EMSC Data Analysis Resource Center (NEDARC) (www.nedarc.org), which assists EMSC grantees and state EMS offices to improve their ability to collect, analyze, and utilize data to improve the quality of pediatric care.

EMSC also has been a very important source of funding for "targeted issues" and "demonstration" grants that have contributed to increasing evidence-based care for acutely ill and injured children. Research is an essential element in the development of an evidence-based practice of medicine. The practice of evidence-based pediatric emergency medicine is needed to provide the best treatment for acutely ill or injured children. It is unfortunate that, in many situations, emergency care providers must rely on limited or anecdotal experience or an extrapolation from adult-care standards when treating children, because reliable research studies involving acutely ill and injured children are few.

Although sufficient numbers of children suffering from some common pediatric illnesses or injuries may be available for scientific study at a single large pediatric center, many other important and potentially debilitating acute pediatric illnesses and injuries are too infrequent to be studied adequately without the participation of multiple centers. The infrastructure of the Pediatric Emergency Care Applied Research Network (PECARN), was created and funded by the EMSC program in 2001 (www.pecarn.org). This research network is a vitally important venue in which multicenter collaborative research regarding the care of acutely ill and injured children has begun.[4] PECARN has experienced substantial growth, having just completed its third year; the network already has competed successfully for 6 federally funded research projects and has completed its first large-scale epidemiological research project. Without the infrastructure support of the EMSC program, the PECARN network would not exist. Ongoing funding for this network is critical to ensure that we gather the best evidence on which to base the treatment of critical illnesses and injuries in children.

The EMSC program has therefore been active on many fronts benefiting the interests of the children for whom we care. Many of the standards for the care of ill or injured children we take for granted today may never have been achieved without the focused pediatric initiatives and funding resources provided through the EMSC program. Although there have been significant advances in the delivery of emergency care to children, for several reasons a substantial gap between pediatric and adult emergency care still exists.[5]

The EMSC program is now threatened by the Bush Administration's recent budget proposal and federal authorization and appropriation legislative functions. Authorization is the statutory, legal authority to spend money for a given purpose or program. If an authorization expires, a program does not necessarily cease to exist; if funding continues to be allocated, the program can continue. For example, the authorization for the National Institutes of Health expired in 1999. However, reauthorization is an important process, because it provides the opportunity to review the scope and effectiveness of programs and make needed changes.

EMSC's continued existence is threatened by the expiration of its current authorization this fiscal year and by recent legislative efforts to reauthorize the trauma program. In the 108th Congress (2003–2004), a trauma authorization bill (HR 3999) was introduced in the House of Representatives that would have eliminated EMSC as a free-standing program and would have rolled EMSC, and its funding, into the trauma program. Although the trauma program is admittedly underfunded, this legislation would have likely eliminated nearly all funding for non–trauma pediatric emergency care issues and the key programs supported by EMSC. Therefore, HR 3999 was strongly opposed by the AAP and several other professional and pediatric advocacy organizations. This opposition was effective in preventing the approval of HR 3999 by Congress in 2004. However, there are signs that the same bill could be reintroduced during the 109th Congress.

Opposition to HR 3999 does not mean that the pediatric EMS community opposes strong trauma legislation. In fact, those same advocacy groups that have voiced opposition to HR 3999 have come together in their support of a bill recently introduced into the Senate. The Senate has proposed its own trauma authorization bill (S 265), one that leaves EMSC and its funding intact. Assuming EMSC survives the trauma reauthorization intact, there is yet another hurdle to face. In 1998, the EMSC program was reauthorized for a rare 7-year period. This authorization is scheduled to expire this year. Trauma aside, this means that EMSC itself will come under scrutiny for reauthorization this year.

EMSC could still receive continued funding in the absence of authorization. Although failed reauthorization represents a threat, a successful reauthoriza-

tion may provide an opportunity. One clear example of that opportunity is the limit imposed by the language of EMSC's current authorization; specifically, the EMSC community might wish to expand the program's authority to include the direct funding of research and promote an evidence-based practice of pediatric emergency medicine. Some have also offered the suggestion that any change in public policy related to EMSC should await the report of the Institute of Medicine (IOM) Committee on the Future of Emergency Care in the US Health System (www.iom.edu), scheduled to be released in the spring of 2006.

Appropriations, the annual federal budget process, represents a perennial challenge faced by EMSC. Thanks to hard work and broad-based advocacy, annual funding support for EMSC has grown steadily over the past 20 years, from $2 million to $20 million. Every February, the President proposes a budget that serves as a starting point for Congress. House and Senate Budget Committees then examine the President's budget, make various changes and adjustments, and determine an overall allocation within which each of the appropriations subcommittees must work. Last year, the administration requested $19 million for EMSC in fiscal year 2005, and Congress allocated $20 million.

The biggest threat to the EMSC program currently is the proposed elimination of funding in the President's fiscal year 2006 budget proposal, which would effectively eliminate the program. EMSC is just one of many important federal programs that were not funded in the President's current budget proposal. Although it has been well over a decade since this last occurred, the EMSC program has been "zeroed out" before in administration budget proposals only to be funded through the decision made by a congressional appropriations subcommittee, driven largely by coordinated political advocacy.

Nevertheless, the lack of request for funding of EMSC in the President's fiscal year 2006 budget is a cause for serious concern and a call for action among advocates for acutely ill and injured children. Although EMSC has successfully navigated many of these challenges in the past, the hurdles the program now faces seem especially perilous. The combination of program reauthorization and appropriation, the potential threat of trauma authorization, the large federal budget deficit, and the nation's economic forecast have created a true cause for concern.

So what can each of us do to advocate for EMSC? First, we must become familiar with the contributions of EMSC, as outlined above, and the process and participants in the upcoming legislative events that may determine the future of EMSC. Each of us can be an effective advocate for children and EMSC through our local institutions or simply as concerned citizens. Our elected officials and their appointed support staff need to become familiar with the many great things that have been accomplished through the EMSC program. In conveying this message, local examples are more compelling than national experiences. We also would be wise to follow the lead of experienced political advocates and lobbyists within stakeholder professional organizations such as the AAP and American College of Emergency Physicians. We should all contact our members of Congress on this issue, which can be done by e-mail (see www.house.gov and www.senate.gov to find your representatives and senators) or through the Capitol switchboard (202-224-3121).

The good news is that EMSC still has advocates in both the Senate and House of Representatives. We need to work effectively with these elected officials in all sectors and in a bipartisan fashion to assure the continued presence and funding of EMSC and the future of the children we serve. We hope that this celebration of 20 years of the EMSC program will also be a celebration of all the great things that are yet to come from a vigorous, innovative, well-funded EMSC program.

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