**Chapter 4   
Legislation, regulation, and ordinance**

**Dan Manz**

**Introduction and brief history**

The history of EMS in the United States is remarkably brief. Many regard the report *Accidental Death and Disability: The Neglected Disease of Modern Society* [1] in 1966 as the foundation from which organized EMS systems emerged throughout the country. Shortly thereafter, the US Department of Transportation released its first curriculum for training personnel as Emergency Medical Technician-Ambulance in 1969. The National Registry of EMTs (NREMT) was formed in 1970 to certify the entry-level competence of EMS personnel. The EMS Systems Act of 1973 provided critical support for states to begin organizing their EMS systems. More recently, the 1996 National Highway Traffic Safety Administration-sponsored *EMS Agenda for the Future* (the Agenda) described a futuristic vision of EMS as “… community-based health management that is fully integrated with the overall health care system” [2].

In the context of systems that are not yet 50 years old, it should come as no surprise that the legislation, regulation, and ordinance governing these systems are still maturing. In 2010, the National Association of State EMS Officials (NASEMSO) published a *Model Statutory and Regulatory Content for State EMS Systems* [3]. This document was created in response to a report by the Institute of Medicine, titled *Emergency Medical Services at the Crossroads*[4]. Among other subjects, the report cites various problems with the state regulation of EMS systems. NASEMSO piece is intended to be a guide that states can use as a model for improving or reforming the content of their existing statutes.

**Physician oversight of EMS systems**

Emergency medical services systems provide emergency health care to patients in the out-of-hospital setting. Services are typically performed by non-physician personnel who are not independent practitioners. EMS personnel operate with defined scopes of practice using physician-approved protocols for care. Such personnel typically provide services on behalf of an EMS agency. The quality measures, relationships of system participants, education requirements, competency verifications, documentation expectations, and many other elements of the EMS system structure are usually defined in some form of legislation, regulation, or ordinance.

Integral to the provision of quality out-of-hospital emergency medical care through EMS personnel has been physician medical oversight. This physician involvement is relatively simple to understand and more complex to put into action. Emergency physicians have the legitimate role and responsibility to determine and guide the management of patients requiring emergency care, whether in the hospital or outside the hospital. An April 2009 joint statement by the American College of Emergency Physicians (ACEP), the National Association of EMS Physicians (NAEMSP), and NASEMSO on the subject of state EMS medical direction reads:

Dedicated and qualified medical direction is required to ensure safe and quality patient care. Medical direction is a fundamental element of the emergency medical services (EMS) system. It is essential that the lead agency for EMS within the fifty states, the District of Columbia, Puerto Rico, the territories of Guam, the Virgin Islands, American Samoa, and the Commonwealth of the Northern Marianas Islands, has a state EMS medical director.

The state EMS medical director provides specialized medical oversight in the development and administration of the EMS system and is an essential liaison with local EMS agencies, hospitals, state and national professional organizations, and state and federal partners. The state EMS medical director provides essential medical leadership, system oversight, coordination of guideline development for routine and disaster care, identification and implementation of best practices, system quality improvement, and research. The state EMS medical director is essential to the comprehensive EMS system at the local level by promoting integration of direct and indirect medical oversight for the entire emergency health care delivery system.

The state EMS medical director should be a physician with extensive experience in EMS medical direction and an unrestricted medical license within the state. Ideally, the state EMS medical director will be a board-certified emergency medicine physician.

State EMS medical direction requires political, administrative, and financial support to achieve these goals. The foundation of the relationship between the state EMS lead agency and the state EMS medical director, including the job description, responsibilities and authority, should be clearly defined within legislation, regulation, or a written contract. The state EMS medical director should be provided with mutually agreed upon compensation for services, necessary materials and resources, and liability protection specific to the unique duties and actions performed.

In summary, ACEP, NAEMSP, and NASEMSO strongly encourage the establishment of a regular full-time position for a state EMS medical director in all fifty states, the District of Columbia, Puerto Rico, the territories of Guam, the Virgin Islands, American Samoa, and the Commonwealth of the Northern Marianas Islands.

The same concepts of essential medical leadership, system oversight, coordination of guideline development for routine and disaster care, identification and implementation of best practices, system quality improvement, and research apply to physicians involved in EMS medical oversight at a regional or local level. Understanding the medical oversight model and the statutes, rules, or other authorities that enable it is important for every physician who provides out-of-hospital emergency care or is involved with the treatment of patients who may be served by the EMS system. It is equally important for physicians to become aware of the procedures and opportunities to influence these bodies of public policy. [Chapter 8](https://jigsaw.vitalsource.com/books/9781118990827/epub/OPS/Vol2/c08.xhtml) of this volume addresses this subject more extensively. Emphasis in this chapter is put on statutes at the state level because these often drive the arrangements for managing EMS systems down to the local level.

**The role of legislation, regulation, and ordinance**

The foundation of EMS legislation, regulation, and ordinance is protection and specifically the protection of patients served by EMS. This is a legitimate and important consideration, particularly in light of the setting in which EMS occurs.

When patients select primary care physicians, they have many options for learning about practitioners. Most states provide publicly accessible databases that include information about licensure status, academic background, practice specialty, hospital affiliations, and malpractice experience. The public can see this information, speak with trusted friends and neighbors about their experiences with a particular physician, talk to other health care providers, or pursue other means to learn about a physician in advance of establishing a doctor–patient relationship.

When a person dials 9-1-1 with a medical emergency, the experience is very different. Patients have no choice about who arrives to provide their care. Patients in an emergency environment are poorly equipped to protect themselves against incompetent practice. Often, they open their homes to EMS personnel they have never previously met and about whom they know nothing. These EMS personnel are given access to the patient’s medications and sensitive information about their medical history, all at a time when the patient may be unable to observe the EMS personnel’s actions. The EMS experience often takes place with virtually no advance notice. Patients count on these people to safely and effectively provide life-saving interventions, many of which carry significant risk if not done properly. It is easy to see in this circumstance why there is a public interest in the cautious and conservative regulation of EMS. The role that physicians are assigned in statutes, rules, or other authorities to oversee and assure the quality of EMS in the out-of-hospital setting is an important public protection responsibility.

**The language and structure of legislation, regulation, and ordinance**

Terminology surrounding the subjects of EMS legislation, regulation, and ordinance can sometimes be confusing. States may use slightly different titles for similar bodies of public policy. The Minnesota Legislature’s website provides a useful discussion of terminology regarding laws, statutes and rules that is broadly applicable to most states [5].

* *Statutes,* also called *laws, codes,* or sometimes *legislation*, are federal or state laws that have been created by acts of publicly elected members of Congress or a state legislature. Most state EMS statutes tend to be written in fairly broad language. Often their purpose is to describe the duties and authority of a responsible state EMS agency. State statutes frequently establish structures such as EMS advisory committees or councils.
* *Rules,* sometimes also called *regulations,* are typically created by a state agency under authority provided in a state statute. Rules often have similar enforceability as statutes. They are usually created through an administrative procedure where notice of the rule-making process is given and there is an opportunity for public input. Rules are often more technically detailed than statutes and frequently are longer.
* *Ordinances* are municipal or local laws. They may be created by a city, county, town, village, or borough under an authority delegated in state statute. Ordinances often deal with matters of public safety, health, and morals. Communities may establish noise ordinances, leash laws, or building codes that define local standards for the subject of the ordinance. At the community level, ordinances often deal with important EMS matters such as cost, level of service, response times, vehicle and equipment specifications, quality management provisions, and similar subjects of EMS operations.

Central to the concept of statutes, rules, and ordinances is that no lower-level language may conflict with or supersede that of a higher level. Federal statutes trump state statutes. State rules may not usurp language established in state statutes, and ordinances typically may not conflict with state rules. Beyond statutes, rules, and ordinances are other legal or quasi-legal documents that affect the provision of EMS. *Contracts* may exist between private EMS providers and counties, cities, or towns for the provision of EMS. Contracts are agreements between parties for compensation in exchange for goods or services delivered and sometimes penalties for failure to perform. *Policies* exist within all forms of EMS agencies to describe expectations or requirements for all matters of daily operations.

Emergency medical services legislation, regulation, and policy evolve constantly. Federal statutes are the most difficult to change. State statutes represent the next level of effort to modify. State rules or regulations are normally easier to amend than state statutes. Local, county, or municipal ordinances or policies may be less complicated to change than state rules or regulations. Contracts often have periodic opportunities to be amended or renewed. Local EMS agency policies and procedures are generally the easiest to modify.

One strategy for establishing standards in statutes and rules is *incorporation by reference*. An example of this is the *National EMS Scope of Practice Model* (Scope Model) [6]. The Scope Model was established as a component of *The EMS Education Agenda for the Future: A Systems Approach*(Education Agenda) [7]. The Scope Model is a voluntary form intended for use by individual states to establish their specific scopes of practice for EMS personnel. It was developed through a consensus process that included broad input from all elements of the EMS community. The Scope Model represents a floor rather than a ceiling, with the intent that all states who use it assure that EMS personnel licensed in their state are authorized to perform at least the specified skills and interventions. While a state can elect to add more education and skills to a particular level, the Scope Model sets a common expectation that states can have when EMS personnel move between one state and another. Some states have begun to incorporate the Scope Model by reference in their laws or rules. The Scope Model is intended to evolve in the future as more evidence for safe and effective EMS practice is established. States that have incorporated it by reference do not need to reopen their legislative or rule-making processes to make updates. This is an important strategy that enables the debate and discussion of best practice and scientific evidence to occur among the relevant professional EMS organizations rather than within the halls of elected officials who often have little technical knowledge of medical practice. Incorporation by reference has gained popularity with the proliferation of technology that enables most source documents to be easily accessed through the internet.

The incorporation of the Education Agenda is a good example of successful policy implementation using the concept of incorporation by reference as well as other concepts mentioned above. In 1998, at the request of NASEMSO, NHTSA supported the development of the Education Agenda*.* This document followed the original EMS Agenda for the Future with a specific focus on establishing a national system of EMS education that would parallel other allied health professions. The Education Agenda has five components: core content, scope of practice model, education standards, national certification, and national EMS program accreditation. Implementation of the Education Agenda has been a significant national undertaking that was completely voluntary by states. Many implementation efforts are still ongoing.

As states have moved to implement the Education Agenda, most have had to amend components of their EMS statutes and/or rules. The majority of states now require NREMT certification to become state licensed, although this is not all states and not for all levels of licensure. Eligibility to hold NREMT certification as a paramedic now requires graduation from an accredited program of education. Accordingly, states that require NREMT certification for paramedics have also either directly or *de facto* established a requirement for national paramedic program accreditation by the Committee on Accreditation of Educational Programs for Emergency Medical Services Professions (CoAEMSP). As many states adjust their statutes and rules to reflect adoption of the Education Agenda, the language of each state’s statutes and rules is not standardized but the concepts behind these licensing and certification authorities are becoming more aligned.

National implementation of the Education Agenda is also helping to standardize terminology about the authorization for EMS personnel to function. The Education Agenda calls the verification of entry level competence by NREMT a “*certification.*” The document issued by the state EMS authority enabling a person to function is called a “*license.*” Some have felt that the term *license* implies an independence of practice that is not accurate for EMS personnel given their relationship with medical oversight. In reality, states are free to enact any requirements they wish on the practice of licensed EMS personnel, including requirements to function under medical oversight. This concept parallels the licensure of other allied health professions and reflects the increasing professionalism of EMS personnel. As states incorporate by reference requirements for NREMT certification and CoAEMSP program accreditation into their statutes and rules, they are establishing a standard that will periodically update automatically as the EMS profession evolves without the need to adjust a state’s individually created standard.

**Authorities established by states and examples of state-specific language**

The language, content, and structure of state EMS laws and rules vary considerably. To date, there has been little effort to standardize the approach states take to regulating EMS, although there is some evidence to suggest that pattern may be changing.

A state EMS statute with broad authority will commonly address the following system components.

* System leadership, organization, regulation, and policy
* System financing
* Human resources and requirements for education, certification, and licensure
* Transportation by ambulance services
* Systems for regionalization of facilities and specialty care
* Public access and communications
* Public information, education, and prevention
* Clinical care and medical oversight
* System evaluation and research
* Large-scale event preparedness and response

In some cases, these topical components are addressed in other statutes rather than a single comprehensive EMS statute. One example is large-scale event preparedness and response which is sometimes established in the state’s emergency management statute.

Here are some state-specific examples of statute language that represents some of the subjects commonly found in state statutes. These examples illustrate the diversity of approaches state legislatures have taken in assigning responsibilities for EMS oversight, medical direction, exemptions from liability, and other subjects.

This is the language in the Nebraska EMS statute that establishes authority for their state EMS office to create rules and the scope of subjects those rules may address [8].

The board shall adopt rules and regulations necessary to:

1. (a) For licenses issued prior to September 1, 2010, create the following licensure classifications of out-of-hospital emergency care providers: (i) First responder; (ii) emergency medical technician; (iii) emergency medical technician-intermediate; and (iv) emergency medical technician-paramedic; and (b) for licenses issued on or after September 1, 2010, create the following licensure classifications of out-of-hospital emergency care providers: (i) Emergency medical responder; (ii) emergency medical technician; (iii) advanced emergency medical technician; and (iv) paramedic. The rules and regulations creating the classifications shall include the practices and procedures authorized for each classification, training and testing requirements, renewal and reinstatement requirements, and other criteria and qualifications for each classification determined to be necessary for protection of public health and safety. A person holding a license issued prior to September 1, 2010, shall be authorized to practice in accordance with the laws, rules, and regulations governing the license for the term of the license;
2. Provide for temporary licensure of an out-of-hospital emergency care provider who has completed the educational requirements for a licensure classification enumerated in subdivision (1)(b) of this section but has not completed the testing requirements for licensure under such subdivision. Temporary licensure shall be valid for one year or until a license is issued under such subdivision and shall not be subject to renewal. The rules and regulations shall include qualifications and training necessary for issuance of a temporary license, the practices and procedures authorized for a temporary licensee, and supervision required for a temporary licensee;
3. Set standards for the licensure of basic life support services and advanced life support services. The rules and regulations providing for licensure shall include standards and requirements for: Vehicles, equipment, maintenance, sanitation, inspections, personnel, training, medical direction, records maintenance, practices and procedures to be provided by employees or members of each classification of service, and other criteria for licensure established by the board;
4. Authorize emergency medical services to provide differing practices and procedures depending upon the qualifications of out-of-hospital emergency care providers available at the time of service delivery. No emergency medical service shall be licensed to provide practices or procedures without the use of personnel licensed to provide the practices or procedures;
5. Authorize out-of-hospital emergency care providers to perform any practice or procedure which they are authorized to perform with an emergency medical service other than the service with which they are affiliated when requested by the other service and when the patient for whom they are to render services is in danger of loss of life;
6. Provide for the approval of training agencies and establish minimum standards for services provided by training agencies;
7. Provide for the minimum qualifications of a physician medical director in addition to the licensure required by section 38-1212;
8. Provide for the use of physician medical directors, qualified physician surrogates, model protocols, standing orders, operating procedures, and guidelines which may be necessary or appropriate to carry out the purposes of the Emergency Medical Services Practice Act. The model protocols, standing orders, operating procedures, and guidelines may be modified by the physician medical director for use by any out-of-hospital emergency care provider or emergency medical service before or after adoption;
9. Establish criteria for approval of organizations issuing cardiopulmonary resuscitation certification which shall include criteria for instructors, establishment of certification periods and minimum curricula, and other aspects of training and certification;
10. Establish renewal and reinstatement requirements for out-of-hospital emergency care providers and emergency medical services and establish continuing competency requirements. Continuing education is sufficient to meet continuing competency requirements. The requirements may also include, but not be limited to, one or more of the continuing competency activities listed in section 38-145 which a licensed person may select as an alternative to continuing education. The reinstatement requirements for out-of-hospital emergency care providers shall allow reinstatement at the same or any lower level of licensure for which the out-of-hospital emergency care provider is determined to be qualified;
11. Establish criteria for deployment and use of automated external defibrillators as necessary for the protection of the public health and safety;
12. Create licensure, renewal, and reinstatement requirements for emergency medical service instructors. The rules and regulations shall include the practices and procedures for licensure, renewal, and reinstatement;
13. Establish criteria for emergency medical technicians-intermediate, advanced emergency medical technicians, emergency medical technicians-paramedic, or paramedics performing activities within their scope of practice at a hospital or health clinic under subsection (3) of section 38-1224. Such criteria shall include, but not be limited to: (a) Requirements for the orientation of registered nurses, physician assistants, and physicians involved in the supervision of such personnel; (b) supervisory and training requirements for the physician medical director or other person in charge of the medical staff at such hospital or health clinic; and (c) a requirement that such activities shall only be performed at the discretion of, and with the approval of, the governing authority of such hospital or health clinic. For purposes of this subdivision, health clinic has the definition found in section 71-416 and hospital has the definition found in section 71-419; and
14. Establish criteria and requirements for emergency medical technicians-intermediate to renew licenses issued prior to September 1, 2010, and continue to practice after such classification has otherwise terminated under subdivision (1) of this section. The rules and regulations shall include the qualifications necessary to renew emergency medical technicians-intermediate licenses after September 1, 2010, the practices and procedures authorized for persons holding and renewing such licenses, and the renewal and reinstatement requirements for holders of such licenses.

Maine’s EMS structure is interesting in that it is one of only a few states where the state EMS agency is a stand-alone entity that is attached to the Public Safety Department for administrative purposes only. This statute defines the powers and duties of Maine's EMS Board [9]. In Maine’s case, the EMS Board appoints the state EMS director and state EMS medical director, and oversees the functions of the state EMS office.

1. Powers and duties. The board has the following powers and duties.
   1. The board shall conduct an emergency medical services program to fulfill the purposes, requirements and goals of this chapter. The board shall adopt the forms, rules, procedures, testing requirements, policies and records appropriate to carry out the purposes, requirements and goals of this chapter. [1991, c. 588, §6 (AMD).]
   2. Notwithstanding any other provision of law, any rule-making hearing held under this chapter and required by the Maine Administrative Procedure Act, Title 5, chapter 375, must be conducted by the board, the director or other staff as delegated by rule or a person in a major policy-influencing position, as defined in Title 5, section 931, who has responsibility over the subject matter of the proposed rule. [1991, c. 588, §7 (AMD).]
   3. The board shall appoint a licensed physician as statewide emergency medical services medical director and may appoint a licensed physician as statewide assistant emergency medical services medical director. These physicians shall advise Maine Emergency Medical Services and shall carry out the duties assigned to the medical director pursuant to this chapter, or as specified by contract. A person appointed and serving as the statewide emergency medical services medical director or statewide assistant emergency medical services medical director is immune from any civil liability, as are employees of governmental entities under the Maine Tort Claims Act, for acts performed within the scope of the medical director's duties. [2011, c. 271, §6 (AMD).]
   4. Rules adopted pursuant to this chapter must include, but are not limited to, the following:
      1. The composition of regional councils and the process by which they come to be recognized;
      2. The manner in which regional councils must report their activities and finances and the manner in which those activities must be carried out under this chapter;
      3. The requirements for licensure for all vehicles, persons and services subject to this chapter, including training and testing of personnel; and
      4. Fees to be charged for licenses under this section. [2011, c. 271, §7 (AMD).]
   5. With the approval of the commissioner, the board shall appoint a Director of Maine Emergency Medical Services.

This portion of Montana statute specifically exempts civil liability for local EMS medical directors with limited compensation for their services [10].

1. A physician, physician assistant, or registered nurse licensed under the laws of this state who provides online medical direction to a member of an emergency medical service without compensation or for compensation not exceeding $5,000 in any 12-month period and whose professional practice is not primarily in an emergency or trauma room or ward is not liable for civil damages for an injury resulting from the instructions, except damages for an injury resulting from the gross negligence of the physician, physician assistant, or nurse, if the instructions given by the physician, physician assistant, or nurse are:
   1. consistent with the protocols and the offline medical direction plan approved by the department in licensing the emergency medical service; and
   2. consistent with the level of licensure of the emergency medical services personnel instructed by the physician, physician assistant, or nurse.
2. An individual who volunteers or who is reimbursed $5,000 or less in any 12-month period for providing offline medical direction is not liable for civil damages for an injury resulting from the performance of the individual's offline medical direction duties, except damages for an injury resulting from the gross negligence of the individual.

Here is an example of the New Hampshire statute that describes the function of a state medical control board that includes the appointment of a physician as the state’s EMS medical director [11].

*Emergency Medical Services Medical Control Board; Chair; Duties; State Medical Director.* –

1. There is established an emergency medical services medical control board which shall consist of:
   1. A minimum of 5 physicians representing different geographic areas of the state who shall be nominated by the councils established under RSA 153-A:6 and confirmed by the board and a physician representative of the trauma medical review committee.
   2. The commissioner, or designee, who shall serve as a nonvoting member and as executive secretary.
2. The terms of each member shall be 3 years. The chair shall be appointed by the commissioner, and the appointed chair shall become the state medical director. The emergency medical services medical control board shall nominate one of its members to the governor for appointment to the coordinating board established in RSA 153-A:3.
3. The duties of the emergency medical services medical control board shall include, but not be limited to, the following:
   1. Assisting the coordinating board in the coordination of a system of comprehensive emergency medical services and the establishment of minimum standards throughout the state by advising the coordinating board on policies, procedures, and protocols.
   2. Providing technical services required by the division pursuant to RSA 153-A:7, I and the coordinating board.
   3. Serving as a liaison with medical personnel throughout the state.
   4. Submitting to the commissioner standardized protocols concerning patient care to consider for adoption as rules, which shall address prerequisites within protocols governing their use by providers, living wills established under RSA 137-H, durable powers of attorney for health care established under RSA 137-J, and patient-requested, physician generated orders relative to resuscitation.
   5. With the concurrence of the state pharmacy board, specifying noncontrolled prescription drugs that emergency medical care providers licensed under this chapter may possess for emergency use as authorized in RSA 318:42, X.
   6. With the concurrence of the state pharmacy board, specifying controlled prescription drugs that advanced emergency medical care providers licensed under this chapter may possess for emergency use as authorized in RSA 318-B:10, V.
   7. Approving the protocols and procedures to be used by emergency medical care providers under their own licenses or through medical control.
   8. Adopting statewide adult and pediatric resuscitation protocols for licensed emergency medical care providers.

This Missouri statute defines the role of regional medical directors [12].

*Regional EMS medical director, powers, duties.*

190.103. 1. One physician with expertise in emergency medical services from each of the EMS regions shall be elected by that region's EMS medical directors to serve as a regional EMS medical director. The regional EMS medical directors shall constitute the state EMS medical director's advisory committee and shall advise the department and their region's ambulance services on matters relating to medical control and medical direction in accordance with sections 190.001 to 190.245 and rules adopted by the department pursuant to sections 190.001 to 190.245.

2. A medical director is required for all ambulance services and emergency medical response agencies that provide: advanced life support services; basic life support services utilizing medications or providing assistance with patients' medications; or basic life support services performing invasive procedures including invasive airway procedures. The medical director shall provide medical direction to these services and agencies in these instances.

3. The medical director, in cooperation with the ambulance service or emergency medical response agency administrator, shall have the responsibility and the authority to ensure that the personnel working under their supervision are able to provide care meeting established standards of care with consideration for state and national standards as well as local area needs and resources. The medical director, in cooperation with the ambulance service or emergency medical response agency administrator, shall establish and develop triage, treatment and transport protocols, which may include authorization for standing orders.

4. All ambulance services and emergency medical response agencies that are required to have a medical director shall establish an agreement between the service or agency and their medical director. The agreement will include the roles, responsibilities and authority of the medical director beyond what is granted in accordance with sections 190.001 to 190.245 and rules adopted by the department pursuant to sections 190.001 to 190.245. The agreement shall also include grievance procedures regarding the emergency medical response agency or ambulance service, personnel and the medical director.

The language in this portion of Vermont’s EMS statute is an example of a state that incorporated by reference the National EMS Scope of Practice Model [13].

1. (10) Establishing, by rule, license levels for emergency medical personnel. The commissioner shall use the guidelines established by the National Highway Traffic Safety Administration (NHTSA) in the U.S. Department of Transportation as a standard or other comparable standards, except that a felony conviction shall not necessarily disqualify an applicant. The rules shall also provide that:
   1. An individual may apply for and obtain one or more additional licenses, including licensure as an advanced emergency medical technician or as a paramedic.
   2. An individual licensed by the commissioner as an emergency medical technician, advanced emergency medical technician, or a paramedic, who is credentialed by an affiliated agency, shall be able to practice fully within the scope of practice for such level of licensure as defined by NHTSA's National EMS Scope of Practice Model consistent with the license level of the affiliated agency, and subject to the medical direction of the emergency medical services district medical advisor.

This Vermont EMS statute language illustrates the trend towards conversion of nomenclature for the authorization to practice from certification to licensure [14].

*Transitional provision; certification to licensure*

Every person certified as an emergency medical provider shall have his or her certification converted to the comparable level of licensure. Until such time as the department of health issues licenses in lieu of certificates, each certified emergency medical provider shall have the right to practice in accordance with his or her level of certification.

**Federal legislation, regulation, and policy affecting EMS**

It is beyond the scope of this chapter to address all of the relevant federal statutes, rules, and policies that play a role in governing EMS. However, EMS physicians may wish to become familiar with the following examples as they contemplate their role in EMS system oversight.

* **Health Insurance Portability and Accountability Act Rules (HIPAA).** HIPAA requirements are familiar to most physicians. The same provisions that apply in other areas of health care are in force for most EMS operations as well. [www.hhs.gov/ocr/privacy/hipaa/understanding/summary/privacysummary.pdf](http://www.hhs.gov/ocr/privacy/hipaa/understanding/summary/privacysummary.pdf)
* **Emergency Medical Treatment and Active Labor Act (EMTALA**). This link connects to the Centers for Medicare and Medicaid Services website and has a number of resources to assist in understanding EMTALA and its relevant federal rules. [www.cms.gov/Regulations-and-Guidance/Legislation/EMTALA/index.html](http://www.cms.gov/Regulations-and-Guidance/Legislation/EMTALA/index.html)
* **OSHA Standard 1910:120**. The Occupational Safety and Health Administration’s standards regarding hazardous materials. Employers are responsible for protecting the health and safety of their employees who may be exposed to hazardous materials through a variety of means, including personal protective equipment, planning, and training. The OSHA website describes these obligations in detail. The OSHA standards are an example of federal protection for EMS workers that also serve to protect EMS patients through good infection control practices. [www.osha.gov/pls/oshaweb/owadisp.show\_document?p\_table=standards&p\_id=9765](http://www.osha.gov/pls/oshaweb/owadisp.show_document?p_table=standards&p_id=9765)
* **Medicare Claims Processing Manual**[**Chapter 15**](https://jigsaw.vitalsource.com/books/9781118990827/epub/OPS/Vol2/c15.xhtml)**– Ambulance**. Most ambulance services recover at least part of their operating expenses by billing the patients to whom they provide treatment and transportation. Medicare has a significant body of policy that drives the types of services reimbursed, levels of payment through a fee schedule, and other details of documenting services provided. This link goes to the Centers for Medicare and Medicaid Services manual with guidance on ambulance billing. [www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c15.pdf](http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c15.pdf)
* **Fair Labor Standards Act of 1938, 29 U.S.C**. § 201 et seq. sets forth wage requirements and hour restrictions for employees, including compensation for overtime work and minimum wages. This act frequently affects EMS shift configurations, employee work schedules, overtime payments, and other aspects of labor/management relations. The link connects to a pdf file of the full language of the Fair Labor Standards Act. [www.dol.gov/whd/regs/statutes/FairLaborStandAct.pdf](http://www.dol.gov/whd/regs/statutes/FairLaborStandAct.pdf)

**The future of EMS legislation, regulation, and ordinance**

As EMS systems evolve, the language and content of statutes and rules will constantly need to be updated. Here are two examples of initiatives that may necessitate changes in many states.

**Involvement in non-emergency out-of-hospital patient management**

Some EMS systems are becoming involved in community-based programs to assist in managing a variety of chronic health conditions. EMS systems may be well positioned to take on tasks like monitoring patients recently discharged from the hospital in an effort to prevent readmissions. EMS personnel could do relatively simple chores such as assuring that patients have their prescribed medications and are taking them on a regular basis. Taking periodic vital sign measurements and monitoring patient weight could help to head off readmission of patients with congestive heart failure. Some EMS agencies are able to perform dressing changes for postsurgical patients. While the skills and knowledge needed to perform these functions may not exceed an EMT’s or paramedic’s current scope of practice, the application of these services is beyond what most states explicitly authorize today.

**The development of a model interstate compact for EMS personnel licensure**

NASEMSO is currently being supported by the Department of Homeland Security in a project to develop a model for the automatic recognition of an EMS personnel license issued in one state in circumstances where the EMS person needs to work in another state [15]. Interstate compacts exist as an instrument of cooperation between states in many settings. The concept is similar to the national driver’s license compact where a person holding a driver’s license in one state is able to drive in other states so long as that person follows the laws and rules of the road wherever he or she is driving. For a compact to become effective, legislation must be passed by each participating state’s legislature.

**Conclusion**

The entire body of federal, state, and local statutes, rules, ordinances, policies, and other documents of governance is important to the orderly management and oversight of EMS systems. Patient safety is at the heart of most EMS laws and rules because EMS patients are vulnerable by the nature of their conditions and the circumstances under which they require EMS.

Legislation, regulation, and ordinance define the structure of and relationships within EMS systems. The purpose of laws created by elected officials is to define and enable structures as well as granting authorities to them. Technical aspects of EMS systems such as education, testing, vehicle and equipment specifications, or similar matters are generally better described in rules created as part of an administrative process.

Physicians play crucial roles in assuring the medical appropriateness and accountability of EMS systems. EMS legislation, regulation, and ordinance may all serve to define the legal authorities and responsibilities of physicians and others in EMS systems. EMS medical directors need to know what portions of legislation affect their practice in EMS, what roles they are assigned, and how to participate in the processes for updating and improving the applicable bodies of public policy.

**References**

1. 1 Committee on Trauma and Committee on Shock, Division of Medical Sciences, National Research Council, National Academy of Sciences. Accidental Death and Disability: The Neglected Disease of Modern Society. Washington, DC: National Academy of Sciences, 1966.
2. 2 United States Department of Transportation, National Highway Traffic Safety Administration, United States Department of Health & Human Services Public Health Services, Health Resources & Services Administration, Maternal & Child Health Bureau. *Emergency Medical Services Agenda for the Future*. Washington, DC: National Highway Traffic Safety Administration, 1996.
3. 3 National Association of State EMS Officials. *State Emergency Medical Services Systems Model Project: Model Statutory and Regulatory Content for State EMS Systems,* 2010. Available at: [www.nasemso.org](http://www.nasemso.org/)
4. 4 Institute of Medicine. *Emergency Medical Services at the Crossroads*. Washington, DC: Institute of Medicine of the National Academies. 2006.
5. 5 Minnesota Legislature website, Frequently Asked Questions section. Available at: [www.leg.state.mn.us/leg/faq/faqtoc.aspx?subject=7](http://www.leg.state.mn.us/leg/faq/faqtoc.aspx?subject=7)
6. 6 United States Department of Transportation, National Highway Traffic Safety Administration, United States Department of Health & Human Services Public Health Services, Health Resources & Services Administration, Maternal & Child Health Bureau. *National EMS Scope of Practice Model*. Washington, DC: National Highway Traffic Safety Administration, 2007.
7. 7 United States Department of Transportation, National Highway Traffic Safety Administration, United States Department of Health & Human Services Public Health Services, Health Resources & Services Administration, Maternal & Child Health Bureau. EMS Education Agenda for the Future: A Systems Approach. Washington, DC: National Highway Traffic Safety Administration, 2000.
8. 8 Nebraska Revised Statutes, Chapter 38 §38-1217 (2009).
9. 9 Maine Statutes, Title 32, Chapter 2-B, §84 (2011).
10. 10 Montana Code Annotated, Title 50, Chapter 6 §317 (2009).
11. 11 New Hampshire Revised Statutes Annotated, Section 153-A:5 (2006)
12. 12 Missouri Revised Statutes, Title XII, Chapter 190, §190.103, (Aug. 28, 2012).
13. 13 Vermont Statutes Annotated, Title 18, Chapter 17 §906. (10)(A)-(B) (2011).
14. 14 Vermont Statutes Annotated, Title 18, Chapter 17 §906b. (2011).
15. 15 NASEMSO website Model Interstate Compact project description. <http://nasemso.org/Projects/InterstateCompacts/index.asp>