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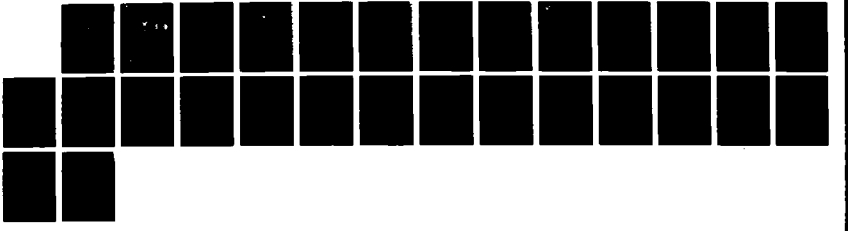

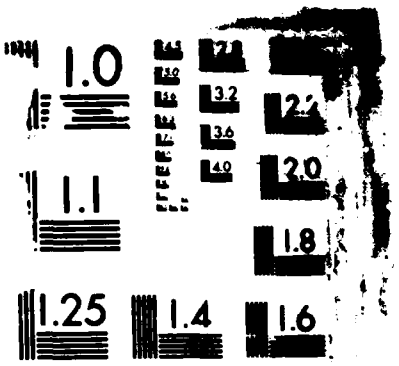
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AIR COMMAND AND STAFF COLLEGE

STUDENT REPORT

NATIONAL REGISTRY OF EMT CERTIFICATION OF AIR FORCE EMERGENCY ROOM TECHNICIANS--IT CAN BE DONE!

MAJOR JACQUELYN J. SUMMERS 87-2415

"insights into tomorrow"

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TITLE NATIONAL REGISTRY OF EMT CERTIFICATION OF AIR FORCE EMERGENCY ROOM TECHNICIANS--IT CAN BE DONE!

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On 18 September 1986 the Deputy Secretary of Defense signed Directive No. 6000.10, Emergency Medical Services. This directive requires all military emergency room technicians be certified by the National Registry of Emergency Medical Technicians as Emergency Medical Technicians - Ambulance. This study provides HQ USAF, Office of the Surgeon General, Director of Professional Affairs and Quality Assurance with some insight into the problems associated with Air Force-wide certification of emergency room technicians and offers recommendations for implementing a certification program Air Force-wide.

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PREFACE

On 18 September 1986 the Deputy Secretary of Defense signed Directive No. 6000.10, Emergency Medical Services. This directive provides all military medical facilities with guidelines regarding the administration and management of emergency medical services. The directive requires all medical technicians assigned to emergency rooms to be certified as Emergency Medical Technicians - Ambulance (EMT-A) with the National Registry of Emergency Medical Technicians (NREMT). The Air Force has until 18 September 1989 to comply with this requirement.

The requirement to certify emergency room technicians as EMT-As presents the Air Force Medical Service with a tremendous challenge. This paper was written to provide HQ USAF, Office of the Surgeon General, Director of Professional Affairs and Quality Assurance with some insight into the problems associated with Air Force-wide certification of emergency room technicians and offer recommendations for implementing the directive.

Many people were consulted during the research for this project and provided valuable support and information. Very special thanks are extended to Major Jan Barber and TSgt Jack Loyd who took time out of their busy schedules to share their knowledge and experience. Many thanks to CMSGT William T. D. Hill, HQ USAF/SGN, CDR Carolyn Carlton (USN) and CDR Mary D. Sattazahn (USN) for their tremendous cooperation and information. A big "thank you" to Lt Col Mickey Mantel, my advisor, for her patience and encouragement throughout this project. A special thanks to my wonderful friends, Majors Lloyd Miller and Pat Tiley-Wilson, for their support and encouragement. This project would not have been possible without Colonel Patricia Williams, HQ USAF/SGPC. A special "thank you" to Colonel Williams for allowing me to take on this challenge.

ABOUT THE AUTHOR

Major Jacquelyn J. Summers received her diploma in nursing from Mastin School of Nursing in 1972 and a Bachelor of Science Degree in Nursing from the Medical College of Georgia in 1973. She was awarded a Master of Science Degree in Adult Education in 1980 from Troy State University. Major Summers entered the Air Force in 1975 and has held positions as a staff nurse, charge nurse of emergency rooms, charge nurse multiservice unit, educational coordinator and instructor, for the USAF School of Health Care Sciences, Nursing Service Management Course.

Major Summers was selected as Sheppard AFB's 1985 Federal Women's Program Outstanding Field Grade Officer of the Year and was included in the 1986 Who's Who in Professional Nursing. Major Summers is currently a member of the Air Command and Staff College class of 1987.

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EXECUTIVE SUMMARY

Part of our College mission is distribution of the students' problem solving products to DoD sponsors and other interested agencies to enhance insight into contemporary, defense related issues. While the College has accepted this product as meeting academic requirements for graduation, the views and opinions expressed or implied are solely those of the author and should not be construed as carrying official sanction.

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REPORT NUMBER 87-2415

AUTHOR(S) MAJOR JACQUELYN J. SUMMERS, USAF, NC

TITLE NATIONAL REGISTRY OF EMT CERTIFICATION OF AIR FORCE EMERGENCY ROOM TECHNICIANS--IT CAN BE DONE!

I. Purpose: To provide HQ USAF, Office of the Surgeon General, Director of Professional Affairs and Quality Assurance with recommendations to comply with the Department of Defense Emergency Medical Services Directive's requirement for emergency room technicians to be certified by the National Registry of Technicians-Ambulance (EMT-A).

II. Problem: The requirement for EMT-A certification of emergency room technicians presents the problem of how to accomplish the required EMT-A certification and recertification of emergency room technicians Air Force-wide.

III. Data: The DoD Emergency Medical Services Directive signed by the Deputy Secretary of Defense on 18 September 1986 includes a policy statement dealing with the training of emergency room technicians. Page 4, Para D4 states, "Technicians or hospital corpmen working in emergency medical services and/or assigned to ambulance duty shall have a minimum of Emergency Medical Technicians - Ambulance current certification from the National Registry for Emergency Medical Technicians." The effective date for this requirement is as soon as possible, but in no case more than three years from 18 September 1986. This training requirement presents several problems for the Air Force Medical Service.

CONTINUED

There are varied problems associated with developing and maintaining EMT-A programs such as management of training programs, certification and recertification of medical technicians and providing required continuing education. The training, testing and meeting continuing education requirements of the NREMT can create a staffing crisis for the medical facility tasked with certifying its emergency room technicians as EMT-As. Aside from manpower considerations, the cost of implementing the training the first year, Air Force-wide, is estimated to be $139,459. This amount includes the cost of NREMT certification fees and purchase of textbooks and audiovisual equipment for the estimated 2500 Air Force medical technicians needing this training. The estimated 30 percent annual turnover rate of EMT-A certified emergency room technicians will result in the training of approximately 750 new EMT-As each year. This will result in an additional annual cost to the Air Force of $11,250; the cost of certification fees.

Although the costs associated with implementing training is an important issue, the impact on staffing is phenomenal. Technicians required to attend EMT-A training programs will be taken away from their duty sections an average of 10 hours a week for 11 weeks. Personnel providing the training, nurses, physicians and medical technicians, will also be away from their duty sections approximately four hours each day they are scheduled to teach. All total, students and instructors will be away from patient care a combined total of 158 hours during an 11 week EMT-A course. EMT-A training and all the other required training such as medical readiness, inservices, infection control and on-the-job training could result in staffing shortages at the expense of quality patient care and morale.

IV. Recommendations: The Air Force Medical Service should step forward and initiate a plan to implement the EMT-A training requirements of the DoD Emergency Medical Services Directive. The medical service should appoint a senior non-commissioned officer or nurse with emergency medicine experience to the School of Health Care Sciences to oversee all EMT-A training. This individual would be the Air Force liaison to the NREMT, having state status with authority to approve all EMT-A training programs. All Air Force medical facilities would submit their

programs to the Air Force liaison for approval rather than through the state in which the medical facility resides. This plan would begin the process of certifying emergency room technicians until the following plan could be initiated.

This plan is modeled after the Navy Medical Command's training program. All students in the School of Health Care Science's 24 week Basic Medical Training for Medical Service Specialists are taught most, if not all, of the Department of Transportation's didactic and skill instruction for EMT-A certification. These students could be given the written and skill tests for EMT-A certification prior to graduation. Students would be awarded a provisional certification from the NREMT until such time as they meet the NREMT requirement of six months emergency room experience. Once the six month experience is obtained, the individual would apply for EMT-A certification at no cost to the Air Force. Eventually, all medical technicians would be EMT-A certified eliminating the need for each medical facility to conduct EMT-A training programs. Medical facilities would only have to provide programs required by the NREMT for biennial recertification; continuing education and refresher courses.

A study to determine the impact of EMT-A training on quality of care and morale of staff should be conducted two years after implementing the directive.

The Air Force Medical Service should start to develop a plan to meet the EMT-A training requirement of the DoD Emergency Medical Services Directive. Careful planning will result in an organized program and will eliminate a crisis management situation. The Air Force Medical Service can continue its commitment to quality emergency care by having its emergency rooms staffed by nationally certified emergency medical technicians.

DEFINITIONS

For the purpose of this paper, the following terms and definitions will be used:

1. Department of Transportation (DOT) curriculum: A training program developed and published by the U.S. Department of Transportation. Is recognized by the National Registry of Emergency Medical Technicians as the model curriculum for training emergency medical technicians.

2. National Registry of Emergency Medical Technicians (NREMT): A national certification agency for emergency medical technicians established in 1970. Is a not-for-profit, independent, non-governmental agency that establishes standards, professional status and proper recognition for emergency medical personnel and training.

3. Emergency Medical Technician - Ambulance (EMT-A): A medical technician assigned to the emergency room and trained according to DOT curriculum or equivalent program approved by the National Registry of Emergency Medical Technicians (NREMT), has successfully completed the NREMT Basic EMT written and practical examinations and has six months emergency room experience as required by the NREMT for certification as an EMT-A.

4. Emergency Medical Technician - Intermediate: A medical technician certified as an EMT-A and has successfully completed an EMT-Intermediate training program. This is a step above EMT-A certification but is not equivalent to EMT-Paramedic certification.

5. Emergency Medical Technician - Paramedic: A medical technician who is certified by the NREMT as an EMT-A or EMT-Intermediate and has successfully completed EMT-Paramedic training that equals or exceeds the behavioral objectives of the National Standard EMT-Paramedic Curriculum as developed and promulgated by the U.S. Department of Transportation.

INTRODUCTION

The quality of military health care has been under scrutiny within the past five to seven years. The news media, from newspapers to television, has examined and criticized the quality of care provided in military medical facilities. One area within the military medical environment that has received a great deal of attention is the emergency room. The actions of emergency room personnel can mean the difference between life and death during medical emergencies. One inexperienced or untrained individual during a critical situation can make a difference.

All personnel eligible for military health care should be assured of quality care provided by fully trained and qualified personnel. This is especially true when seeking care in the emergency room. The Department of Defense conducted an extensive quality assurance audit of selected military emergency rooms and concluded the training and experience of medical technicians assigned to emergency room duty were insufficient (2:3; 5:3,11). As a result of this finding, the Department of Defense has directed all emergency room technicians be certified through the National Registry of Emergency Medical Technicians (NREMT) (3:2). Technicians assigned to emergency rooms must be certified by the NREMT as Emergency Medical Technicians - Ambulance (EMT-A) and maintain this certification as long as they are assigned to military emergency rooms (3:2). Air Force medical treatment facilities have three years from 18 September 1986 to implement this directive (3:7). This requirement for EMT-A certification presents a challenge to the Air Force Medical Service; how to comply with this Department of Defense directive.

Complying with the directive presents the following two problems:

a. How can the training required for the NREMT Emergency Medical Technician - Ambulance (EMT-A) certification be accomplished?
b. How can the continuing education requirements for EMT-A biennial reregistration be accomplished?

PURPOSE AND OVERVIEW

The purpose of this paper is to provide HQ USAF, Office of the Surgeon General, Director of Professional Affairs and Quality Assurance with recommendations that best answer the above questions. This paper is divided into four chapters. Chapter one provides background information. Chapter two is a discussion

of National Registry of Emergency Medical Technicians certification and recertification requirements as they pose problems associated with complying with the DoD directive. Chapter three outlines some considerations for specific problems addressed in chapter two and three recommendations for implementing the directive and their advantages and disadvantages. Chapter four provides the summary and conclusion.

CHAPTER ONE

BACKGROUND INFORMATION

On January 26, 1983, the Secretary of Defense requested a Defense-wide audit of military health care. The audit was performed in selected Army, Navy and Air Force hospitals from May 1983 to October 1984 by auditors of the Department of Defense (DoD) and Auditors General of the Army, Navy and Air Force (2:1). The objective of the audit was to provide independent validation of the effectiveness of actions taken by the military services to improve the quality of care provided at military medical facilities (2:1).

The audit revealed a significant problem regarding experience and training of emergency room personnel. According to the Summary Report On the Defense-wide Audit of Medical Quality Assurance, 83 of 168 physicians, nurses and medical technicians assigned to emergency rooms at six medical facilities were inexperienced or lacked the necessary training in emergency care (2:3). Although other problems regarding emergency room care were revealed during the audit, for the purposes of this paper only those problems regarding the training of emergency room technicians will be addressed.

In response to the emergency room discrepancies revealed during the Defense-wide audit, the Assistant Secretary of Defense (Health Affairs) sponsored the DoD Emergency Medical Services Conference in November 1984 (2:12). This conference developed strategies for improving the quality of care provided by military emergency departments and provided input for the Department of Defense Emergency Medical Services Directive (2:12). The directive requires all emergency room technicians meet the basic Department of Transportation Emergency Medical Technician training standards (5:Part 6).

The DoD Emergency Medical Services Directive was signed by the Deputy Secretary of Defense on 18 September 1986. Included in this directive is a policy statement dealing with the training of emergency room technicians. Page 4, Para D4 states,

> Technicians or hospital corpsmen working in emergency medical services and/or assigned to ambulance duty shall have a minimum of Emergency Medical Technician - Ambulance (EMT-A) current certification from the National Registry for Emergency Medical Technicians

(NREMT). EMT-Intermediate or EMT-Paramedic current certification as defined by the NREMT also may fulfill this requirement (3:2).

The effective date for this requirement is as soon as possible, but in no case more than three years from 18 September 1986 (3:7). There are several problems associated with implementing this requirement within the Air Force and these are addressed in chapter two.

Chapter Two

PROBLEMS WITH IMPLEMENTATION

This chapter addresses problems of implementing the training requirements of the DoD Emergency Medical Services Directive. Discussed here are the problems associated with developing and maintaining EMT-A programs; management of training, certification and recertification of EMT-As and continuing education requirements. The issue of the cost of complying with the directive is also examined. This paper provides a breakdown of the costs of certification/recertification fees, books and audiovisual aids.

In conducting an EMT training program, one must take into consideration such issues as qualifications of course staff, class size, medical equipment required and available for training, course content and evaluation of students. Careful selection of EMT course staff comprised of a course director, clinical director and instructors, is important to ensure a quality training program. The course director is the "coach" and manager of the EMT training team and requires careful selection.

A course director is needed to oversee the entire EMT course. This individual should have appropriate credentials in both prehospital emergency care and educational administration (9:--). The course director is important to the overall success of the program. The planning, scheduling, coordinating, teaching, and administering of EMT-A programs are just some of the responsibilities of the director. Many facilities may have to appoint a course director as an additional duty or have a full time director at the risk of jeopardizing staffing.

The next critical position on the staff is the clinical director. The clinical director should be a physician specializing in or have extensive experience in emergency medicine (9:--). This individual is responsible for the clinical portions of the EMT-A program and oversees all skills testing.

After these key positions have been filled, instructors must be selected to teach the course. All lectures, discussions and practical sessions must be taught by physicians, nurses, physician assistants or emergency room technicians with extensive experience in prehospital emergency care or who are specialists in a specific topic area for both didactic and practical subjects; i.e., obstetrics, orthopedics and pediatrics.

Instructors for the cardiopulmonary resuscitation portion of the EMT course must be certified by the American Heart Association or the American Red Cross as Basic Cardiac Life Support Instructors (9:--).

The next factors to be considered are class size and equipment for training. In conducting an EMT course, instructors should carefully determine class size for lectures as well as practice sessions. Limiting class size to eight allows for close interaction between students and instructors. Requirements for equipment used in teaching EMT courses are outlined in the Department of Transportation Curriculum for Emergency Medical Technicians. Some medical facilities may find they do not have all the required equipment such as Thomas splints, Hare traction, MAST trousers, or extrication tools. The lack of equipment may cause delays in training as well as increase training costs.

After the selection of course staff has been accomplished, class size determined, and equipment for training has been obtained, the course content must be developed. Course content, to comply with the DoD Emergency Medical Services Directive and the NREMT, must reflect all required lesson topics as defined in the Department of Transportation Curriculum for Emergency Medical Technicians (1:3). The NREMT requires at least a 110 hour course (9:--). This brings us to another problem; how much time is this 110 hour course going to take the emergency room technicians and course staff away from their duty sections?

In an interview, TSgt Jack Loyd, NCOIC of Nursing Education at USAF Regional Hospital Maxwell, provided some answers to this question. TSgt Loyd explained that the EMT-A course requires students to attend classes at least ten hours a week for eleven weeks and is conducted during duty hours. Not only are the medical technicians who attend the course taken away from their duty section for classes, those teaching the courses are also taken away from their duty section. For a 110 hour EMT-A course, approximately four physicians, three physician assistants, two nurses and three experienced emergency room technicians could conceivably be used for teaching (8:--). Each of these individuals would spend an average of four hours away from their duty section on the days scheduled to teach their portion of the course (8:--). Students and instructors would be away from their jobs a combined total of 158 hours over the eleven weeks. Having personnel in the classroom for 158 hours can have a significant impact on manpower. Unfortunately, these hours are only for the initial training of EMT-As and do not even include additional training required by the NREMT.

Once the individual has completed training and receives certification from the NREMT, training does not stop. The NREMT requires 48 hours of continuing education for the biennial recertification plus an EMT-A refresher course (1:6-7). TSgt

Loyd conducts a 21 hour EMT-A refresher course on a Monday through Friday schedule, four hours per day during duty hours (8:--). These requirements present the same problems to staffing as previously discussed. The hours an EMT-A program takes students and instructors from their duty sections is in addition to all the other training required; medical readiness, on-the-job training, in-services, and other annual training requirements. The emergency room cannot afford to be short staffed. This critical area must have a full complement of qualified personnel 24 hours a day, 7 days a week. It must be fully staffed at all times to provide emergency ambulance response, inflight emergency coverage and disaster response. These duties are in addition to providing care to patients seeking treatment in the emergency room. Depending on the size of the medical facility, three to six medical technicians may be required to staff the emergency room during each shift of duty. Removing one or two technicians from duty to attend or provide training could create a manpower shortage, thus, diminishing the quality of care in the emergency room and decreasing morale of personnel.

The manpower problems associated with implementing EMT-A training programs present a tremendous challenge. The cost of implementing training programs Air Force-wide does not present as formidable a challenge. In looking at costs, it is important to know how many medical technicians are affected by this directive. There are approximately 2500 medical service technicians currently working in the emergency room or eligible for assignment to the emergency room (7:--). All these technicians require NREMT EMT-A certification. Based on these numbers, the cost of certifying all of these technicians would be $37,500. This cost is based on the $15 fee required by the NREMT for certification (1:3). Each of these 2500 technicians will require EMT-A recertification on a biennial basis at a cost of $10 per person. This will be an additional $25,000 biennially.

Additional costs to be addressed are the books and audiovisual aids needed for EMT-A training. Although there are several different books on the market, the author has determined the most economical is Prehospital Emergency Care and Crisis Intervention, 2nd Ed. which is sanctioned by the NREMT. The textbook sells for $22.95 and the workbook for $8.95 (8:--). If each Air Force medical treatment facility (CONUS and overseas) purchased 15 textbooks and 20 workbooks, the cost would amount to $64,883. This amount is the initial cost to purchase all required texts. An additional annual cost of $22,196 would be required to purchase workbooks for continuation training. A 35 mm slide program to accompany the textbook is available for $299 (8:--). If each medical treatment facility purchased this program, the cost to the Air Force would be $37,076; a one-time purchase.

Having determined the cost of certifying the 2500 emergency room technicians currently in need of certification, the cost of books and slides to accompany the texts, it is time to see what the total cost will be to the Air Force. The total price tag for the first year of implementing the requirement for EMT-A training is estimated to be $139,495. As with any career field, there will be a certain number of emergency room personnel to leave the Air Force. This turnover of personnel will impact on annual costs. The estimated annual turnover rate of EMT-A certified emergency room technicians Air Force-wide is 30 percent or approximately 750 emergency room technicians (7:--). This would require an additional annual cost to the Air Force of $11,250. The $11,250 is based solely on the NREMT $15.00 certification fee. This chapter has provided a look at some problems associated with implementing EMT-A training Air Force-wide. The management of training, certification and recertification of personnel all pose significant manpower problems. Medical facilities will have the responsibility of providing EMT-A training for emergency room personnel without increased manpower to relieve staffing shortages. The cost of implementing EMT-A training programs Air Force-wide presents somewhat less of a challenge. The first year cost of the program is estimated to be $139,495. Although this figure is not overwhelming, funds may be difficult to obtain due to increased cuts in defense spending.

The problems of manpower and costs present a tremendous challenge to the Air Force Medical Service. The next chapter provides some recommendations to assist the medical service in complying with the EMT-A training requirements.

Chapter Three

RECOMMENDATIONS

This chapter provides recommendations to help the Air Force Medical Service comply with the DoD Emergency Medical Services Directive requirements. The author first provides considerations of specific problems outlined in Chapter two. Next, the author describes three recommendations for implementing the directive Air Force-wide. The advantages and disadvantages of the three recommendations are also discussed.

CONSIDERATIONS OF SPECIFIC PROBLEMS DISCUSSED IN CHAPTER TWO

Chapter two addressed problems associated with developing and maintaining EMT-A training programs. One such problem is selecting a course director to oversee the entire program. The author suggests a senior Non Commissioned Officer (NCO) with extensive emergency room experience or the NCO of Nursing Education. A nurse with experience and training in prehospital care or the emergency room could also assume this position. Another problem is appointing a clinical director with emergency medicine experience. Since many facilities may not have a physician with an emergency medicine background, an alternative is necessary. Many Air Force medical facilities use the chief of hospital services or an internal medicine physician in this capacity. The NREMT approves such alternatives.

The next problem is the equipment for training. If a facility does not have all of the necessary equipment or the funds to purchase it, there are some possible solutions. One solution is to borrow equipment from local emergency medical services. Not only can they lend equipment, they can also provide personnel to demonstrate its use. Because of their experiences in prehospital care, they make excellent instructors who can provide students with real-life situations. A second solution to the problem of obtaining training equipment is to seek help from the base fire department and/or the flightline crash rescue department. These departments can also provide equipment and training for vehicle extrication classes required for EMT-A certification. Local and base emergency medical services can provide the medical facility valuable equipment and instructors to defray costs and minimize staffing burdens.

The problem of providing 48 hours of continuing education, required by the NREMT for EMT-A biennial recertification can be a difficult challenge, however, creativity and efficient use of other training requirements can provide valuable solutions. These 48 hours can be obtained through attendance at inservices, intravenous therapy certification classes, infection control classes, pharmacology courses, as well as Medical Red Flag training classes. The NREMT does recognize most, if not all, of these as acceptable for the 48 hour requirement. Medical facilities could also provide funding to allow some of its EMT-As to attend state or regional emergency medical services continuing education programs but this would not be feasible for all EMT-As due to the cost involved.

Having provided some considerations for specific problems addressed in chapter two, recommendations for the implementation of EMT-A training Air Force-wide will be discussed next.

RECOMMENDATION 1 - STATE-APPROVED TRAINING

This recommendation requires each facility to develop its own state-approved EMT-A program. This would require each medical facility to work through the emergency medical services office of the state in which the facility is located and follow that state's guidelines for EMT-A training. Each facility would train all technicians assigned to the emergency room who currently do not hold EMT-A certification from the NREMT. Each facility would also certify not less than ten percent (10%) of its 90250 personnel. This would ensure a cadre of certified personnel to pull from in the event of emergency room personnel shortages; i.e., short notice moves, losses due to illness or disciplinary action. Requirements for continuing education and EMT-A refresher training would be conducted in accordance with state emergency medical services guidelines. Overseas medical facilities could submit their EMT-A programs directly to the NREMT for approval or utilize on-base colleges, such as the City College of Chicago, found throughout Europe and the Pacific (9:--).

ADVANTAGES AND DISADVANTAGES OF RECOMMENDATION 1

Advantages

The first advantage is, by using state-approved training programs, EMT-A students and the medical facility would enhance their stature among the local emergency medical services. This would demonstrate to the local community a commitment to provide quality emergency care. The second advantage is to the EMT-A course director. By working through the state emergency medical services office, the course director would be provided clear-cut

guidance to use in developing and managing the EMT-A course. The director would have a point of contact should any questions or problems arise regarding training. Now, for the disadvantages.

Disadvantages

The first disadvantage is that each state has different requirements for training, certification, continuing education and recertification. If an EMT-A moved to a different state, they would then have to abide by that state's EMT-A requirements for recertification. The second disadvantage involves overseas medical facilities. These facilities would have to work directly through the NREMT which could cause some delays in program approvals.

A CAVEAT TO FURTHER RECOMMENDATIONS

Before moving on to the next recommendations, a caveat is in order here. The author recommends the Air Force receive status from the National Registry of Emergency Medical Technicians (NREMT) as opposed to endorsement by each state's emergency medical services. This process is quite simply a matter of submitting a letter of request from the Air Force Surgeon General's office to Mr. Waco Morando, Executive Director of the NREMT. Mr. Morando has stated he would welcome the request (9:--). The author also recommends appointing either a senior NCO or nurse with emergency room experience to the USAF, School of Health Care Sciences, Department of Nursing, as the "state" liaison to the NREMT. This individual would be the approval authority for all Air Force EMT-A training programs. This would eliminate problems associated with medical facilities working with individual state emergency medical services and would also ensure more standardization of training within the Air Force. The next recommendations are dependent on the above conditions.

RECOMMENDATION 2 - SCHOOL OF HEALTH CARE SCIENCES PROVIDES TRAINING

This recommendation is modeled after the Navy Medical Command's training program (4:3; 6:--). Most, if not all, of the Department of Transportation (DOT) didactic and skill instruction for EMT-A certification is currently taught at the USAF School of Health Care Sciences 24 week Basic Medical Training for Medical Service Specialists (10:--). The author recommends Course J3AQR90320-003, Medical Service Specialist and Course J3ABP90230-003, Medical Service Specialist - Clinical which provide all of the DOT curriculum requirements for EMT-A certification. Before graduation from the eight week clinical program, students would be administered the NREMT written and clinical exams for EMT-A provisional certification. The funding

for the $15 NREMT test fee would be provided by Air Training Command. Test results would be sent from the NREMT to the graduate's gaining medical facility. The gaining medical facility would provide the necessary recertification requirements and emergency room experience that allows the individual to become EMT-A certified. Individuals who could not be provided emergency room experience within the NREMT time limits, would be certified as EMT-Non-ambulance personnel until such time as they meet the experience requirements for EMT-A certification (1:3). Once the experience requirement is met, the individual would then apply to the NREMT for EMT-A certification. The NREMT does not charge a fee for this change in certification status. The only cost for the medical facility would be the individual's biennial (once every two years) ten dollar recertification fee.

ADVANTAGES AND DISADVANTAGES OF RECOMMENDATION 2

Advantages

There are four advantages to this recommendation. The first advantage of this recommendation would be the high quality and standardization of training provided by the faculty of the Medical Service Specialist course. The second advantage would be the motivation of the students enrolled in the Medical Service Specialist course. These are highly motivated and disciplined young men and women eager to learn new skills and who have not had the time to learn poor habits. Third, by providing the initial EMT-A training in the Medical Service Specialist Course, all medical facilities can eventually eliminate their initial EMT-A training courses and provide only the required recertification training courses; EMT-A refresher courses and continuing education. This would mean more technicians on the job rather than in training or providing training. There are approximately 1800 graduates from the Medical Service Specialist Course each year (10:--). Based on this figure, the author estimates within five years, most medical treatment facilities would have enough certified EMT-As to staff their emergency rooms. The fourth advantage involves the number of personnel involved in training. By only having to provide recertification training, medical facilities would only have to utilize one or two trainers versus four or five necessary to conduct initial EMT-A programs. The advantages to this recommendation far outweigh its disadvantages.

Disadvantages

The disadvantage of this recommendation is the additional time the Medical Service Specialist - Clinical Course may have to be extended to provide the EMT-A written and clinical testing. After reviewing the tentative course chart for the Clinical

Course, it is the author's opinion one or two days of extension would be necessary.

RECOMMENDATION 3 - AIR FORCE OBTAINS NREMT STATE STATUS

This recommendation is similar to Recommendation 1. Rather than use individual states for EMT-A program approval, medical facilities would use the Air Force NREMT liaison as discussed in the caveat. This recommendation is modeled after the Navy Medical Command's EMT-A training program (4:5-6; 6:--). If Recommendation 2 is adopted, eventually each medical facility would no longer need to train a cadre of EMT-As as was described in Recommendation 1. If Recommendation 2 is not adopted, each facility would continue to train a cadre of EMT-As using Air Force NREMT liaison-approved training programs. Overseas medical facilities would also submit their programs to the Air Force liaison for approval.

ADVANTAGES AND DISADVANTAGES OF RECOMMENDATION 3

Advantages

This recommendation provides three advantages to the Air Force. First, by having the Air Force NREMT liaison as approval authority, there is greater standardization and quality control of programs. The elimination of individual state emergency medical services as approval authority for Air Force EMT-A programs is another advantage. The task of providing EMT-A training to overseas personnel will be much simpler and less costly having the Air Force NREMT liaison as approval authority for its programs.

Disadvantages

The need to obtain reciprocity from individual states is a disadvantage for Air Force EMT-As. EMT-As seeking employment with local emergency medical services would have to obtain reciprocity from the state in which their medical facility is located. This process could involve obtaining additional training or retesting for certification in that state.

This chapter has provided considerations for specific problems outlined in chapter two and recommendations for the implementation of EMT-A training Air Force-wide.

Chapter Four

SUMMARY AND CONCLUSION

SUMMARY

The purpose of this paper has been to provide HQ USAF, Office of the Surgeon General, Director of Professional Affairs and Quality Assurance with recommendations to comply with the EMT-A training requirements of the DoD Emergency Medical Services Directive. Chapter one provided a historical overview of the events leading to the DoD Emergency Medical Services Directive signed 18 September 1986. Chapter two discussed problems associated with implementing the training requirements of the directive; management of training, certification, recertification and costs. Chapter three provided recommendations to comply with EMT-A training requirements of the directive. It included suggested specific considerations for those problems discussed in chapter two and provided three recommendations for implementing EMT-A training Air Force-wide.

CONCLUSION

The DoD Emergency Medical Services Directive has presented the Air Force Medical Service with a tremendous challenge. While the Air Force has three years to implement this directive, it is in the best interest of emergency room personnel and the patients they serve to develop plans now. Our sister services, the Army and, most notably, the Navy have stepped forward and taken the initiative to develop model EMT-A training programs. The Air Force Medical Service may find itself in a crisis management situation if it does not take the initiative to begin a plan of compliance with the directive.

Air Force families deserve to receive only the very best in emergency care by professionally trained personnel. The Air Force Medical Service can strengthen its commitment to quality emergency care by moving rapidly forward in meeting the challenge presented by the DoD Emergency Medical Services Directive.

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