



Designation: F 1339 – 92 (Reapproved 1998)

Standard Guide for Organization and Operation of Emergency Medical Services Systems¹

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1. Scope

1.1 This standard established guidelines for the organization and operation of Emergency Medical Services Systems (EMSS) at the state, regional and local levels. This guide will identify methods of developing state standards, coordinating/managing regional EMS Systems, and delivering emergency medical services through the local EMS System.

1.1.1 At the state level this guide identifies scope, methods, procedures and participants in the following state structure responsibilities: a) establishment of EMS legislation; b) development of minimum standards; c) enforcement of minimum standards; d) designation of substate structure; e) provision of technical assistance; f) identification of funding and other resources for the development, maintenance, and enhancement of EMS systems; g) development and implementation of training systems; h) development and implementation of communication systems; i) development and implementation of record-keeping and evaluation systems; j) development and implementation of public information, public education, and public relations programs; k) development and implementation of acute care center designation; l) development and implementation of a disaster medical system; m) overall coordination of EMS and related programs within the state and in concert with other states or federal authorities.

1.2 At the regional level, this guide identifies methods of planning, implementing, coordinating/managing, and evaluating the emergency medical services system which exists within a natural catchment area and provides guidance on the use of these methods.

1.3 At the local level, this guide identifies a basic structure for the organization and management of a local EMS system and outlines the responsibilities that a local EMS should assume in the planning, development, implementation and evaluation of its EMS system.

2. Referenced Documents

2.1 ASTM Standards:

F 1086 Guide for Structures and Responsibilities of Emer-

gency Medical Services Organizations²

F 1149 Practice for Qualifications, Responsibilities, and Authority for Individuals and Institutions Providing Medical Direction of Emergency Medical Services²

F 1220 Guide for Emergency Medical Services System (EMSS) Telecommunications²

F 1268 Guide for Establishing and Operating Public Information, Education and Relations Programs for Emergency Medical Services Systems²

F 1285 Guide for Training the Emergency Medical Technician (Basic) to Perform Patient Examination Techniques²

2.2 American Ambulance Association
Standards and Accreditation Document³

3. Significance and Use

3.1 This guide suggests methods for organizing and operating state, regional, and local EMS systems, in accordance with Guide F 1086. It will assist state, regional, or local organizations in assessing, planning, documenting, and implementing their specific operations. The guide is general in nature and able to be adapted for existing EMS Systems. For organizations that are establishing EMS System operations, the guide is specific enough to form the basis of the operational manual.

4. State Guide

4.1 Establishment of EMS Legislation:

4.1.1 *Methods and Procedures*—The legislative process varies from state to state. The EMS lead agency should seek a description of the process in its state from:

4.1.1.1 The legislature's staff or clerk offices.

4.1.1.2 The legislative liaison, or other appropriate staff of the governmental unit housing EMS (its "umbrella").

4.1.1.3 The legal counsel assigned to EMS.

4.1.2 Legislative proposals are commonly subject to the following processes:

4.1.2.1 *Drafting*—The standard-setting or other goal is put into general form by the agency, citing the sections of statute it believes are affected. The entities listed in 4.1.1-4.1.1.3 may be a resource, or may be required to be involved, in this proposal development.

¹ This guide is under the jurisdiction of ASTM Committee F30 on Emergency Medical Services and is the direct responsibility of Subcommittee F30.03 on Organization/Management.

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² Annual Book of ASTM Standards, Vol 13.02.

³ Available from the American Ambulance Association.



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TABLE 1

	State	Regional ^A	Local
Standard Setting	Legislation Regulations Guidelines/policies/procedures State protocols	Regional policies Regional protocols Assistance re: personnel	Employment standards Operating policies
System Coordination	Statewide coord. and planning Licensure/certification Facility licensure Service approval/licensure Training approval MIS/QA Inter-regional coord. Inter-state coord. Statewide SMI planning Design of sub-state structure	System planning Implementation Inter-organizational coordination Regional SMI Medical audit/QA Operational coordination System evaluation Personnel authorization accreditation	Daily operations
Service Delivery	Training Technical assistance Communications guidelines Funding PI&E	Training coordination Group purchasing Technical assistance PI&E	First response Ambulance (BLS, ALS; ground, helicopter, fixed wing) Hospital services PI&E

^AIf there are no regional organizations, within the state, the State EMS will need to accomplish, either directly or through delegation, regional tasks.

4.1.2.2 Sponsorship— The proposal may be submitted through the agency’s “umbrella” department to become an official part of the administration’s legislative initiative. Whether this is true or not, the umbrella’s legislative liaison will generally seek the sponsorship of appropriate legislators for the bill unless the bill is opposed by the administration. Sponsorship might be sought directly by the agency or by third parties on the agency’s behalf under certain circumstances where practical.

4.1.2.3 Final Drafting and Introduction—The bill may be drafted in the form technically required for consideration by the legislature in the umbrella unit and/or legislative counsels offices. It is then read in the legislature and generally referred to a committee.

4.1.2.4 Committee Consideration—The committee usually holds a public hearing at which the agency and others may testify in favor of or against the bill, or neutrally. In subsequent, scheduled work sessions the bill is considered, changed as necessary, and some action usually voted. Agency and lobbyist attendance at work sessions is common and often influential.

4.1.2.5 Adoption/Rejection—Bills voted out to the legislature by committee, favorably or otherwise, are then read and voted on by that body.

4.1.2.6 Governor—Bills adopted by the legislature may be signed, not signed (but not vetoed), or vetoed by the governor. Bills that are vetoed may be returned to the legislature to attempt to override the veto. Bills that are not vetoed generally become law immediately if designated as emergency bills, or some time after the legislature adjourns as prescribed by law.

4.1.3 The timing of legislative proposal submissions, and the tracking of their progress to assure agency input are critical to their success. Hearing announcements and progress reports generated by the legislature or umbrella unit legislative liaison are useful. A legislative “hotline” is also commonly available and of use in tracking bills but personal contact with legislative aides and/or committee staff and legal counsels are even more useful.

4.1.4 Participants in the EMS Legislative Process:

4.1.4.1 Drafting/Sponsorship Resources may include:

- (a) A. Umbrella unit legislative liaison,
- (b) B. Assistant attorney general assigned to EMS,
- (c) C. Legislators/aides to legislators,
- (d) D. Staff/legal counsel to committee likely to consider bill, and
- (e) E. Agency staff, or staff of other agencies.

4.1.4.2 Formally Required Reviews/Approvals and/or Informal, Politically Expedient, Reviews/Approvals may be Sought From:

- (a) A. Umbrella unit commissioner/head (cabinet level),
- (b) B. Other agency heads with any potential interest,
- (c) C. State EMS and other advisory boards with potential interest,
- (d) D. REMSO staffs and advisory councils, and
- (e) E. EMS, fire, physician, nurse and other organized, active EMS-related professional associations.

4.1.4.3 Resources for Monitoring Legislative Progress:

- (a) A. Legislature staff/clerk offices and their publications (for example, hearing notices) and hotline,
- (b) B. Committee members and their aides,
- (c) C. Committee staffers and legal counsels, and
- (d) D. Sponsors of bill and their aides.

4.1.4.4 Public Hearing Testimony Resources:

- (a) A. Those listed in 4.1.4.1, A to E, (sponsoring), 4.1.4.2, A to E, (review/approval), and 4.1.4.3, A to D, (monitoring),
- (b) B. Hospital/prehospital personnel, and
- (c) C. Consumers.

4.1.4.5 Governor’s Office Resources:

- (a) A. Umbrella unit commissioner/head (cabinet level),
- (b) B. Aides to Governor (if known and appropriate), and
- (c) C. Legislators and aides with links to Governor.

4.2 Development of Minimum Standards:

4.2.1 Methods and Procedures—A variety of standard-setting mechanisms exist, from that which is formal and explicitly housed in the state’s laws to that which is the least formal, for instance, the non-binding opinion of EMS staff which is standard-setting to the extent of the discretion of the staff.



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“rightness” of the opinion and the perceived expertise of the staff. The most commonly employed method and procedures are listed below.

4.2.1.1 Origins of Standards—State standards should be derived from the ASTM process. When this process has not provided a standard in a needed area, standards set by the National Association of State EMS Directors and/or, secondarily, by other EMS-related professional associations should be used as a foundation.

4.2.1.2 When utilizing standards documents generated by other than the ASTM process, these should be critically reviewed by experts from a range of EMS-related clinical, administrative, training, planning, regulatory and other disciplines. In these cases, this process should assure that all interested parties have an opportunity to comment. Federal standards, in law and otherwise, may exist in certain areas of EMS which may affect a state’s future receipt of federal funds; these should be reviewed for consistency with planned standards.

4.2.2 Specific Methods and Procedures:

4.2.2.1 Legislation— Used for setting broad, legally-binding standards. Sets the responsibilities of the state, regional, and local EMS structures; defines areas of rule or regulation-making authority, and sets general minimum standards for the system as a whole. See 4.1.

4.2.2.2 Rules/Regulations—Used to set more specific standards for system design and operation including, but not limited to, the interaction of state, regional, and local EMS structures in provider operation (for example, licensure, training course approval); requirements for and terms of operation (usually through licensure or certification) for EMS personnel, vehicles, equipment and services; organization of EMS training for certification or licensure; organization of certification or licensure testing; scope of practice; causes and procedures for disciplinary actions. This process is governed by the administrative procedures act (“APA”) of the state and generally requires the EMS rule-making authority to publish notices and hold hearings on proposed changes. Consult the state’s APA and discuss with the legal counsel assigned to EMS.

4.2.2.3 Executive Order— The Governor may be empowered to take actions which have a standard-setting impact. Consult the legal counsel assigned to EMS or the Governor’s staff.

4.2.2.4 Policies/Procedures—Used by the state agency to govern the details of its operations and interactions with providers. Examples could include the personnel licensure/certification application form, procedures for in-state grant programs, or a policy for the administration of state licensure examinations. These are generally created outside of legislative or rule-making arenas. This makes them easier to create than laws or rules but also much less binding upon the EMS system and its providers. In fact, these are generally not considered to be legally binding. They are useful, though, in defining and clarifying required licensure/certification processes for providers and in providing immediate direction to providers where such direction is not provided in law, rules, or elsewhere.

4.2.2.5 Protocols—Virtually unique to EMS in their regional or statewide application, treatment protocols may be

used to set clinical and operational standards and to define scope of practice. Protocols are most effective when they are given power of law by virtue of specific reference in statute (for example, “Treatment shall be in accord with protocols established by the medical director of the state (or regional) EMS agency”). Protocol-development may require a consensus-building process among the state’s medical advisory committee, regional medical directors and others.

4.2.2.6 Contracts and/or Letters of Agreement—Generally in return for funding or other resources, regional and local structures and providers may agree to certain standards of performance. For example, state funding of training courses or ambulance equipment items may be afforded with agreement on standards for course content or equipment use. States generally have a standard process and forms for contracts and grants. Consult the purchasing and/or contracts office or legal counsel assigned to EMS.

4.2.3 Participants in the Development of Minimum Standards:

4.2.3.1 By Legislation— See 4.1.

4.2.3.2 By Rules/Regulations:

- (a) A. Agency staff (drafting),
- (b) B. Legal counsel assigned to EMS (review),
- (c) C. REMSO staffs/advisory councils/committees (review),
- (d) D. State advisory council/committees (review),
- (e) E. State EMS-related professional associations (review),
- (f) F. Impartial legal counsel (approval),
- (g) G. Secretary of state (records/announces proposals, certifies adopted rules),
- (h) H. Legislature (subject to review),
- (i) I. Umbrella unit staff and head (review/approval unless EMS agency has own rule-making authority), and
- (j) J. Providers/general public.

4.2.3.3 By Executive Order:

- (a) A. Agency staff (drafting),
- (b) B. Legal counsel assigned to EMS (review),
- (c) C. Umbrella unit head/commissioner (cabinet level),
- (d) D. Governor; governor’s staff,
- (e) E. State advisory council/committees,
- (f) F. Consider those listed in 4.2.3.2 for review.

4.2.3.4 By Policies/Procedures:

- (a) A. Agency staff (drafting and review),
- (b) B. REMSO staff (review), and
- (c) C. Consider umbrella unit/advisory council review.

4.2.3.5 By Protocols:

- (a) A. Agency staff,
- (b) B. REMSO staff,
- (c) C. State/regional medical directors and medical advisory boards, and
- (d) D. Consider those listed in 4.2.2.2 for review.

4.2.3.6 By Contracts/Letters of Agreement:

- (a) A. Agency staff,
- (b) B. REMSO (contractor or reviewer),
- (c) C. Local system/provider (contractor),
- (d) D. Legal counsel assigned to EMS,
- (e) E. Consider umbrella unit/advisory council review.