THE EMS NEWSLETTER

EMERGENCY MEDICAL SERVICES

DIVISION OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE

MARCH 1974
VOL. 1, NO. 1

A NEWSLETTER FOR EMERGENCY MEDICAL SERVICES

As the new Maryland Statewide Emergency Medical Services System moves forward, it is important for all those providing services and those receiving them to be kept informed of its progress. We have therefore inaugurated The EMS NEWSLETTER that will be published at regular intervals and distributed widely throughout the State.

This first issue contains a feature article summarizing the events that led up to and followed the promulgation of an Executive Order by Governor Marvin Mandel. The Governor's Order, issued one year ago, created the Division of Emergency Medical Services and started Maryland on a path that will further improve the finest EMS system in the country. Subsequent issues will carry feature articles discussing particular topics (for example, the EMS communications system now under development) in greater depth. Each issue will include a calendar of national and Maryland EMS future events; and "SYSTEM UPDATE" will be a column reporting on notable milestones achieved since the previous issue. If you will write them, we will also include a "Letters to the Editor" column.

We in the Division of Emergency Medical Services believe that Maryland's EMS System is of the quality it is because of the dedication and competence of the physicians, nurses, firemen, rescue squads, dispatchers, elected officials and civic leaders that make it work. It is to them that we dedicate the NEWSLETTER. We encourage all of you to provide news items you would like reported in EMS NEWSLETTER.

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MARYLAND EMS –– PROGRESS TO DATE

An Executive Order

Just one year ago, most of the medically knowledgeable would have agreed that there was a great deal of local expertise in the field of emergency medical care. Yet, while good care was available, there was no systematic way of providing it in an optimal fashion. A statewide program was needed to ensure that all persons could receive needed specialized care expeditiously. Thus, stimulated by the personal experience of a close friend that made the need truly evident, Governor Marvin Mandel made two commitments: One, to develop emergency medical care in Maryland to the highest level that the state of the art would allow; and the other, to provide this care to any critically ill or injured person no matter where they might be in the State.

To accomplish these goals, the Governor passed an Executive Order creating two institutions –– a Division of Emergency Medical Services within the Department of Health and Mental Hygiene, and the Maryland Institute for Emergency Medicine (the former Center for the Study of Trauma) in the University of Maryland.

A Regional Concept

With the Executive Order, the pattern was to be changed. A scheme was adopted in which the State is divided into five separate geographic regions. The providers of emergency services in each region––the hospitals, physicians, ambulance and rescue crews, State Troopers, etc.––would coordinate and integrate their local services. At the same time, the five regions would become a part of a total statewide system, capable of delivering fast and effective specialized care to a seriously ill or injured person who could not be properly treated in his own locale.

To bring this objective about, several things are needed. First, advisory councils composed of local providers, non-provider consumers and local governmental officials had to be organized in each region to assume the task of coordinating regional operations, planning regional system improvements, conducting public educational programs, and to serve as a linking body between the local regions and the State Division of Emergency Medical Services. These regional councils also are in the process of evaluating the capabilities of all hospital emergency facilities to know precisely what the capabilities within the region are.

Specialized Care Facilities

Second, unique and highly specialized care facilities have been identified and tied into the system––the Shock-Trauma Center at the Maryland Institute for Emergency Medicine (MIEM), the Burn Unit at Baltimore City Hospital, the Pediatric Trauma Unit at Johns Hopkins Hospital and the neonatal care programs at Baltimore City and University Hospitals are examples. This process is underway, led by the Division of Emergency Medical Services.

Communication––the Keystone - The Three R's

Last, all providers must be linked together through a communication and transportation system to insure that each patient gets exactly the right care at the right facility at the right time. Through a radio and telephone network, instant contact will not only be possible, as now, between ambulance and central dispatcher, but also among the region's ambulances, hospitals, physicians, State Troopers, state helicopter crews and dispatchers. Communications of this sort are crucial for two reasons: First, it guarantees that the patient will be transported to the right facility and second, it allows the rescue technicians to receive immediate instructions from a physician, so care can begin the moment the patient is reached.

Under regional control, the communication network can also be used to obtain instant consultation and transportation to a special care facility through the statewide systems communication center at the MIEM.

The Golden Hour

Key to the plan's success is the absolute assurance that the patient will be taken to a facility that is both expecting him and equipped to deal with his specific problem. In an uncoordinated, non-regionalized system, patients are routinely rushed to the nearest hospital only to find that it is not properly equipped or staffed to treat the condition. The patient is then transported to another facility, perhaps miles and precious minutes away, where again, there may be no one to properly treat him. The delay occasioned by this travel can be deadly –– the Maryland Institute for Emergency Medicine has shown that the first hour after the onset of the illness or injury is the most critical: If the right treatment is begun within that "golden hour", the chances of survival are greatly improved.

Regionalization is Here

Most agencies and institutions dealing with emergency services agree that the system must be regionalized and coordinated if delays are to be avoided and all patients are to receive the best care possible. As a first step, the regions must assess their current capabilities and needs in three areas; rescue equipment (ambulances and communication equipment), rescue manpower and emergency facilities. Once identified, the necessary equipment can be obtained, training programs begun and emergency care moved on its way towards a uniformly high level, statewide.

Emergency Medicine – The
Role of a Shock Trauma Unit
"A Symposium on Multiple Trauma and Shock"
April 11, 1974 Hunt Valley Inn
Interstate 83 at Shawan Road
Hunt Valley, Maryland

In keeping with the State plan, the regional advisory councils have been organized in each of the five regions to coordinate emergency medical services. To date, each council has accomplished the following:

- Appalachia Region (Allegany and Garrett Counties) – A 30-member council, 15 from each county, has been appointed by the two County Commissions. Organized into working committees (legislation and funding, communications, transportation, education and training, plans and development), the Council has started its task of assessing needs and creating a regional EMS plan. First on their agenda is a study of ambulance and ambulance equipment needs in the region.

- Mid-Maryland Region (Frederick and Washington Counties) – The Mid-Maryland Region has formed like (in fact, it preceded) the Appalachia Region. The 30-member Mid-Maryland Regional Advisory Council has already written an 80-page regional action plan, and is starting to initiate projects to satisfy that plan.

- Metropolitan Baltimore Region (Baltimore City and Baltimore, Anne Arundel, Harford, Howard and Carroll Counties) – A private, non-profit corporation––Emergency Medical Services Development, Inc.––has been formed and is serving as the regional EMS Council. It is the recipient of a 1-¼ million dollar Federal grant to develop a demonstration regional EMS communications system, and the hardware is currently being purchased.

- Eastern Shore Region (Cecil, Kent, Queen Annes, Caroline, Talbot, Dorchester, Somerset, Wicomico and Worcester Counties) – This is the last region to be organized; the Council has been formed, bylaws are in the process of adoption, and regional planning should begin soon.

- Metropolitan Washington Region (Montgomery, Prince Georges, Charles, Calvert and St. Mary's Counties) – This region also includes the District of Columbia, and four counties and two cities in northern Virginia––the result of a predecessor committee to the present regional council. Under the aegis of the Regional Medical Program, the forerunner group obtained a $95,000 EMS planning grant for the three-state region which is just being completed.

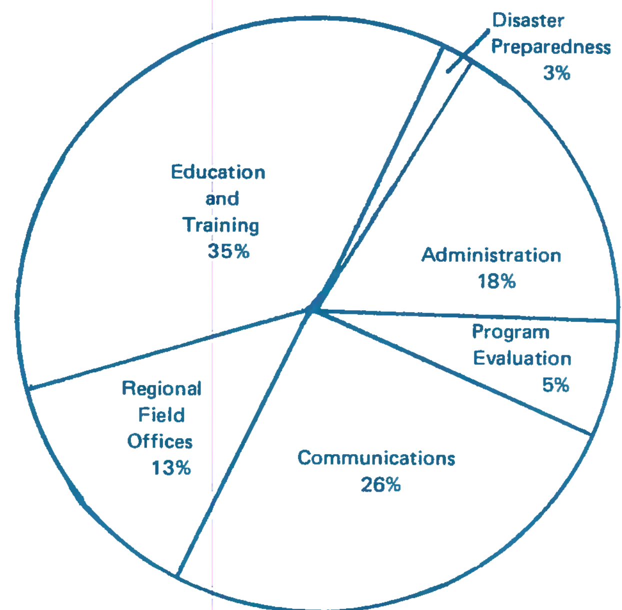
The Budget

The organization of these regional councils is a start, but the communication and transportation systems, a statewide training program and a statewide EMS evaluation system must also be developed——and the latter elements cost money. Thus, the Maryland Legislature presently is being asked to approve a $2.9 million budget to fund the new Division of Emergency Medical Services for the period between April 1, 1974 and July 1, 1975.

The funds will be used by the Division to fully launch the statewide program. A core staff, establishing regional field offices of the Division, building the statewide EMS communications network, developing new educational programs and expanding current EMT-A training, and initiating the evaluation and data collection system are all included in the new budget. These funds will be used by the Division and will not be available for providing direct grants to local providers and agencies. However, federal Department of Transportation and Health, Education and Welfare grant programs are currently being explored to obtain additional funds for local and regional EMS projects.

Of the 2.9 million dollars, about 1.4 million will be used for operating expenses. The chart shows how they will be applied to the program areas; They will support EMS activities in all five regions across the State. The 1.5 million dollar capital budget is almost totally for hardware for the statewide EMS communications system.

The Legislature is completing its review of this budget, and the prospect of passage looks favorable. With that action, Maryland will have taken a giant stride toward the goal that was the dream of Governor Mandel when he started it all with the execution of his Executive Order one year ago.



OPERATING BUDGET

We acknowledge the contribution to the NEWSLETTER of Ms. Barbara Koeppel who developed this lead article.

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MARYLAND EMT-A's — KEEP YOUR RECORDS STRAIGHT

Maryland certified Emergency Medical Technicians-Ambulance and EMT-A Instructors who have participated in additional Emergency Care related training, and who would like to have a record of the training included in their official registry files, are requested to notify the EMT Training Office of the Division of Emergency Medical Services.

Photocopies of letters of completion, diplomas or certificates may be mailed to The Division of Emergency Medical Services, 22 South Greene Street, Baltimore, Maryland 21201, attention: EMT Training Office. If your diploma or certificate does not show completion date and course location, please write this information on the back of the copy. Please do not send the original certificate, as nothing will be returned.

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THE GOALS AND OBJECTIVES OF THE MARYLAND EMS SYSTEM

The Division of Emergency Medical Services has established the following Goal and Objectives to guide its course while implementing the new statewide EMS program.

Goal – The Maryland Statewide EMS Program shall strive toward ensuring that every individual requiring it has the best emergency medical care according to the highest standards of the practice of medicine, regardless of his location, type of emergency, time of need, or personal circumstances.

Objectives

1. Create regional organization and promote the concept that regional EMS councils are responsible for emergency health care in their region.
2. Provide a regional EMS system through a broad-based input of providers, consumers and government.
3. Accomodate all emergencies in the system, including psychiatric, poison, drug overdose, and heart attack, as well as trauma.
4. Provide a voluntary evacuation system to get the emergency critically ill and injured patient to a specialty care center when local resources cannot adequately provide for the patient.
5. Provide for effective and immediate decisions regarding patient care by establishing a statewide communication network.
6. Promote a greater interest and activity in the field of rehabilitation.
7. Improve ambulance service and equipment.
8. Improve emergency departments.
9. Train doctors, nurses, and ambulance personnel.
10. Educate the public.
11. Establish a uniform statewide data collection and analysis methodology for program evaluation.

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SO YOU WANT TO CALL A MEDEVAC CHOPPER

As of March 1974, the Maryland State Police have three functional helicopters in service. The purpose of this State service is to transfer acute critically ill and injured patients to Specialty Care Centers, either from the scene of an accident or from other hospitals at the request of a physician.

Whenever possible, helicopter transportation will be provided for emergency critically ill and injured patients who, because of their life-threatening problems, demand intensive multi-disciplinary treatment and care. Patients with severe multiple injuries, burns, head trauma, overwhelming septicemia, refractory shock, neonatal problems, gas gangrene infections, scuba diving accidents or other entities deemed life threatening by the physician are eligible for this type of transportation.

This program is not designed to handle patient transfers to individual private physicians or institutions other than the Special Care Centers providing an around-the-clock State service. To do otherwise would require a far larger fleet of helicopters than exists at present. Similarly, it is impractical to allow any physician or hospital in the State to summon a helicopter directly –– this rapidly saturates the system. With the limited number of aircraft in the system, central coordination is a necessity.

Requests for Air Medevac service is made by calling (301) 528-6020 or (301) 528-6844. Until further notice, requests for neonatal primary nursery care will be made by calling (301) 342-7432. A physician is always available to consult with the requesting physician or hospital who, in turn, will be immediately notified as to availability of the chopper, time of arrival, etc.

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AMERICAN TRAUMA SOCIETY – MARYLAND DIVISION

The American Trauma Society, an organization of more than 1,300 concerned physicians and laymen, was founded in 1971 to reduce death and disability from trauma by improving emergency care in every community. To seek better emergency care of the injured, the Society has defined six goals: 1) Educate the public to the need for an emergency medical service system, 2) Train people in giving immediate life-saving aid, 3) Improving the methods of speeding help to the scene of an emergency, 4) Upgrade ambulance services, 5) Insure adequate hospital emergency services, and 6) Support research to improve treatment of the trauma patient.

To carry out these goals, efforts are being directed towards establishing state divisions in all regions of the country. Maryland was one of the first nine states to be chartered by the National Office. To date, the Maryland Division has been incorporated, bylaws have been written and selection of the Board of Directors is now underway.

Information and applications for founding membership can be obtained from Dr. R A. Cowley, Maryland Institute for Emergency Medicine, 22 South Greene Street, Baltimore, Maryland 21201. Founding memberships close May 1, 1975. Mr. Harry Rodgers has accepted the appointment as Chairman of the Society.

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EMS CALENDAR

State

March 20 — Appalachia Region EMS Advisory Council; Cumberland, Maryland. 8:00 p.m. (724-1616)*

March 26 — Eastern Shore Region EMS Advisory Council; Easton, Maryland. 7:30 p.m. (228-8911)*

March 28 — Chesapeake Bay Chapter, American Association of Critical Care Nurses: "Cardiogenic Shock and the Use of Intra-Aortic Balloon Pump"; Baltimore, Maryland. (528-6846)*

March 29 — Statewide Regional EMS Advisory Council (REMSAC); Baltimore, Maryland. 2:00 p.m. (528-6846)*

April 2 — Mid-Maryland Region EMS Advisory Council; Hagerstown, Maryland. 7:00 p.m. (663-8300, ext. 250)*

April 11 — Postgraduate Course: Symposium on Multiple Trauma and Shock; Baltimore, Maryland. 8:00 a.m. (Program of Continuing Education, University of Maryland School of Medicine, 29 South Greene Street, Baltimore, Maryland 21201)*

National

March 19 - 24 — American College of Emergency Physicians Symposium and Winter Workshop; New Orleans, Louisiana. (241 East Saginaw, East Lansing, Michigan 48823)*

April 29-May 1 — Eighth International STEP Forum of Emergency Health Services; St. Louis, Missouri. (Wm. F. St.John, 217 Alexander Street, Rochester, New York 14607)*

May 28-June 1 — University Association/EMS Annual Meeting; Dallas, Texas. (UA/EMS, P. O. Box 1241, East Lansing, Michigan 48823)*

May 29-June 1 — American Association of Critical Care Nurses' Annual Convention; New Orleans, Louisiana. (Barbara Arnold, P. O. Box 5445, Orange, California 92667)*

May 30-June 1 — American College of Emergency Physicians Third Annual Scientific Assembly; San Francisco, California. (Paul R. Perchonock, M.D., 897 MacArthur Blvd., Suite 101, San Leandro, California 94577)*

June 6 - 8 — Sixth Annual Education Conference, Association of Operating Room Technicians, Inc.; Washington, D.C. (Steven K. Herlitz, 850 Third Avenue, New York, New York 10022)*

August 26-31 — International Rescue and First Aid Association Convention; Toronto, Canada. (IRFAA, P. O. Box 6218, Cincinnati, Ohio 45206)*

* — Contact for further information

The Calendar is available to announce your meetings. Write John W. Morris, Division of EMS, 22 South Greene Street, Baltimore, Maryland 21201 or call (301) 528-6846.

ACKNOWLEDGEMENTS

There is a large number of dedicated people throughout this State that have been of inestimable value in providing both assistance to the Division of Emergency Medical Services and leadership in their respective regions as the new statewide EMS system takes form. Physicians, elected government officials, firemen, ambulance and rescue squad personnel and others have all been represented in the ranks of those who have served. Room does not permit listing each of these people, to whom we owe a debt of gratitude. There are a few, however, that have handled the daily nitty gritty, the regional staff work, that has made it all possible. We would like to express a special note of appreciation to them and to the agencies that have supported them. They are as follows:

Mr. Robert Kopsack; Health Planning
Council of Appalachia Maryland, Inc.,
Cumberland, Maryland.

Mr. Richard Menconeri; Frederick County
Comprehensive Health Planning Council,
Frederick, Maryland.

Dr. Martin Levy; Metropolitan Washington
Regional Medical Program, Washington, D.C.

Ms. Betty Nelson; Health Planning
Council of the Eastern Shore, Inc.
Cambridge, Maryland.

Mr. John Bybee; Montgomery County
Office of Comprehensive Health Planning,,
Rockville, Maryland.