MARYLAND'S EMERGENCY MEDICAL SERVICE SYSTEM

I. MAGNITUDE OF THE PROBLEM

The failure to provide for emergency illness, accidental death and disability can no longer be tolerated as an insoluable health problem. In Maryland, the medical expertise and technology are now available to reduce accidental death and disability rates in our State. Through better utilization of these existing emergency resources using a total systems approach to emergency health care delivery, immediate improvement in emergency medical care can be realized. Furthermore, geographic factors and the current medical environment in Maryland lend themselves to the initiation of a statewide system of emergency medical services.

When every American has access to first-rate emergency care, we will have satisfied the most urgent demand of our current crisis in health care and guarantee to the consumer

the fundamental health right of all - the right of life.

A. STATISTICS

1. Each year more than 52 million U.S. citizens are injured. Of these, more than 110,000 die, 11 million require bed care for a day or more and 400,000 suffer lasting disability. Thirty 500 bed hospitals.

2. More than 650,000 die annually of ischemic heart disease. About 350,000 of these deaths occur outside the hospital, usually within two hours of the onset of symptoms. Thus, sudden death from heart attacks remains the gravest medical emergency today.

3. This emergency is closely followed by accidental death as a result of drowning electrocution, suffocation, drug and alcohol

intoxication, falls, poisonings, attempted suicide and automobile accidents.

4. Together, sudden death from heart attack and accidental death are responsible for one-fourth of all mortalities in the U.S. annually. However, aggressive emergency medical care without delay, made possible by a preplanned well-organized system of response, could save many of these victims.

II. MARYLAND'S PROGRAM

A. Division of Emergency Medical Services created by Executive Order in 1973. MIEM and DEMS.

B. DEMS a service organization is working with providers of emergency care throughout the State.

C. Overall Goal - insure that every citizen will receive the best emergency medical care regardless of type of illness and injury, its severity, the citizen's personal circumstances or geographical location.

D. Objectives

1. Establish statewide EMS System consisting of regions, sub-regions, local sub-systems and specialty referral facilities coordinated by a communication and transportation network.

2. Provide total emergency care from the time of emergency through resuscitation, definite care and rehabilitation.

3. Develop all phases of the program utilizing community and areawide planning and cooperation.

4. Develop and implement sub-systems in capabilities of hospitals, communications, transportation, training and education, public information and evaluation.

5. Promote the latest concepts of patient management within the hospital environment.

6. Develop methodology utilizing systems analysis techniques for evaluating patient care, education and research.

7. Develop a system of cost-analysis and cost-effectiveness of the delivery of EMS

8. Develop a total system that will be financially and administratively self-supporting within the community.

Thus, the purpose of the statewide EMS program is to improve the delivery of emergency medical care and thereby decrease mortality, morbidity, hospitalization and disability.

III. PROGRESS TO DATE

A. Inventory and Planning

The outcome of any medical emergency depends on two basic factors, the quality of initial, definite and rehabilitative care and the time intervals involved in the delivery of that care. This required a preconceived and coordinated plan, a communication system and professional and allied health personnel cooperating with hospitals, transportation services and the public.

1. Plan developed in 1971 and submitted to

Governor Mandel.

2. More detailed plan submitted to Secretary of Health and Mental Hygiene in 1973.

B. Regionalization

1. Five EMS regions were formed on the basis of jurisdictional patient flow patterns, medical capability and geographical factors. Region I - Appalachia, Region II - Mid-Maryland, Region III Metropolitan Baltimore, Region IV - Eastern Shore, Region V - Metropolitan Washington.

C. Regional EMS Advisory Councils

Council members include hospital authorities, physicians, nurses, County and State health department officials, consumers, representatives of ambulance and rescue organizations, fire and police departments, municipal government and civil defense.

In each region, the EMS Advisory Council determines local EMS needs, coordinates local emergency medical resources and provides regional input into the statewide program.

D. OTHER COUNCILS

1. Regional EMS Advisory Council (REMSAC)

2. Emergency Medical Services Technical Advisory Council (EMSTAC)

3. Medical Management Consultant Group

E. TRAINING AND CONTINUING EDUCATION

During the first critical minutes following injury or sudden severe illness, the ambulance attendant may well be the first medically-trained person to care for the emergency victim. The attendant's competence and level of skill could be the single most important factor in the victim's chances for survival with minumum disability.

1. 81-hour DOT EMT-A Course

2. Over 4,000 ambulance attendants are certified EMT-A. Best anywhere.

3. Cardiac Rescue Technicians program

4. Emergency Department Nurses

5. Emergency Room Physicians

F. COMMUNICATIONS

1. MIEM has demonstrated through fore-warning of patient arrival, including patient status and extent of injuries that emergencies can arrive by appointment.

2. The Maryland EMS Communication System will provide the following capabilities:

   a. Direct medical communications linking the scene of the emergency

locations, ambulances, hospitals, specialty care centers, central alarms and Med-Evac helicopters without disturbing present ambulance dispatch methods and equipment.

b. Ease and flexibility in operation utilizing, rather than duplicating, systems currently in operation within the State.

c. The statewide communication center (SYSCOM) already partially operational coordinates the Med-Evac effort, coordinate EMS activities between regions, provides for medical consultation and provides a backup communication resource for local and national disasters.

IV. PROGRESS IN EASTERN SHORE REGION

A. Selection of a Coordinator - Mark Bramble - and a secretary

B. Establishment of an EMS Office - 12 N. Washington Street, Easton, Maryland

C. Establishment of a Council - Dr. Frank Drews first chairman. Present chairman is Dr. Lewis Himes.

D. Funding in the amount of $40,000 for an HEW planning to develop an EMS regional plan.

E. Regional plan was developed and in conjunction with a statewide application, $60,000 has been awarded for defibrillators for four hospitals, ambulance equipment, hospital signs and high accidental area signs.

F. Council now has the responsibility of evaluating DOT funding requests for ambulance and ambulance equipment.

G. A regional-wide evaluation of hospital emergency service capabilities has been done.

H. A Cardiac Rescue Training Program has been initiated at Peninsula General Hospital

I. Through a position paper prepared by the Council regarding the need for EMT training on the Eastern Shore, such a course will be conducted in each county this year.

V. NEED FOR PHYSICIAN SUPPORT OF THE EVACUATION SYSTEM - COMPLETELY VOLUNTEER SYSTEM

WHY

HOW