Maryland EMS News

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# Critical Incident Stress Management

. In January MIEMSS Executive Director Robert R. Bass, MD, named Craig Coleman as director of the Critical Incident Stress Management (CISM) Program. This statewide program, coordinated by MIEMSS, is available free-of-charge to all emergency services personnel in Maryland who have difficulty coping with symptoms of stress and find them interfering with professional or personal responsibilities. The CISM Program was developed to serve prehospital care providers (career and voluntary; public service and commercial); emergency dispatchers; career and volunteer firefighters; law enforcement personnel; and emergency department staff.

The CISM Program, which began in Maryland in 1986 under the direction of Marge Epperson-SeBour and became a model for other EMS systems, was originally known as the CISD (Critical Incident Stress Debriefing) Program. According to Mr. Coleman, who was one of the original 12 CISD members, the name was recently changed to CISM since the program encompasses stress prevention and management as well as debriefings and defusings.

Mr. Coleman, who divides his MIEMSS responsibilities equally between CISM and prehospital provider continuing education, emphasizes that CISM has strong support from Dr. Bass and that the effectiveness of the CISM Program is due to the 90-member CISM team, consisting of mental health professionals and peer support personnel across the state.

The following is based on an interview with Mr. Coleman.

**Q. What are the goals of the Maryland CISM?**

**A.** The overall goals of the CISM Program are to minimize the effects of job-related stress on EMS providers' professional and personal lives by educating them about the symptoms of stress and ways to manage it. In addition, this year I have two immediate goals:

1. To get more mental health professionals in Regions II and IV involved in CISM. Currently, mental health professionals from other regions have been working with the CISM teams in Regions II and IV to ensure that EMS providers in those regions can receive CISM services if they need them.

2. To establish memorandums of understanding across the state. These memorandums enumerate such items as who should call for the CISM team; how the team should be activated; and what they will do when they arrive. The memorandums also guarantee that the team members will have the most up-to-date information and training in the area of critical incident stress.

**Q. What services does the CISM team offer?**

**A.** *1. Defusings*

• Usually performed after the incident at the incident site or at the station.

• Normally last 15-30 minutes (but length of defusing can vary according to the incident);

• CISM team will explain what symptoms to expect (for example, anxiety, nightmares) and will try to put the incident into perspective, reassuring the EMS provider that, if necessary, a debriefing will follow the defusing at an appropriate time. The goal of the CISM team is not to stop the grieving process or minimize the providers' stress responses. The goal is to educate the providers that these processes may occur and that the team will be available to provide debriefings to help them deal with their emotions. The CISM team will call back 24-48 hours after a defusing to see if a debriefing is needed.

*2. Debriefings*

• Usually performed 48-72 hours after the incident, which is usually the amount of time that elapses before someone can express his/her feelings about an incident. (During the actual incident emergency service providers usually perform at their normal level but are often on "automatic pilot" because there has been no time to process their thoughts and feelings about the incident.)

• The debriefing location is usually determined by the contact person at the agency/service requesting the debriefing. Efforts are made to eliminate distractions (for example,

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## Highlights Inside. . .

# CISM Program

*(Continued from page 1)*
if a debriefing is to occur at a firehouse, it would be recommended that the company be "out of service" during the debriefing).

• CISM team members (mental health professionals and peer support personnel) facilitate discussion among the providers, encouraging them to describe what they saw and how they felt. (Some incidents may bring up feelings related to a past incident.) It is important that providers realize that, in a debriefing, rank structure has no meaning. Debriefings are voluntary and no one is forced to attend or to talk. Hearing other co-workers express feelings similar to their own usually helps group members realize they are not alone and their feelings and behaviors are appropriate for that type of incident. Participants also learn how to release their anger and frustration and to understand what has happened to them.

• A CISM team member will follow up to ensure that EMS providers are receiving additional help, if needed.

*3. Education and Referral Services*

• Lectures and training about stress prevention, critical incident stress management, and stress burnout.

• Upon request, referrals to individual therapists for EMS providers experiencing difficulty in areas not specifically related to a critical incident (for example, family problems).

**Q. When should the CISM team be called?**

**A.** The CISM team is prepared to go anywhere in Maryland when called. However, the team should not be requested on the basis of the type of incident only (for example, requesting the team everytime there is a "disaster"). If the emergency providers are coping well with their stress and it is not interfering with their job, the CISM team does not need to be called. IMPORTANT: Anytime there is any doubt about whether the CISM team should be called, contact should be made so that the CISM team member and the caller can devise an appropriate plan of action.

**Q. What is the advantage of calling the CISM team?**

**A.** There are certain benefits, such as more open and direct discussions, in talking to a stranger. The Maryland CISM team is not associated with a specific agency. No reports are made to the supervisors or superior staff. The CISM team includes peer support personnel from other jurisdictions who can easily relate to the type of incident and subsequent stress experienced by the participants in a particular defusing or debriefing.

**Q. Is confidentiality always maintained?**

**A.** Absolutely. Only the people involved in the incident attend. There are no tapes, and no notes are taken. News reporters are never allowed. In addition, all participants agree to make a pact that everything that is said and done in the room remains in the room. To the best of my knowledge, this pact has never been violated in the 9 years that I've been part of the CISM Program.

**Q. Who is on the CISM team?**

**A.** Currently there are 90 team members: 32 mental health professionals and 58 peer support personnel. All serve strictly as volunteers and are on call 24 hours a day.

The mental health professionals are hospital social workers, psychiatric nurses, psychologists, etc.; all are screened to ensure that their credentials are current, and they have extensive knowledge about the personality profile of emergency services personnel. The peer support personnel are firefighters, police, EMS providers, etc., who personally know the stresses of emergency services

*Craig Coleman*

work and who have been screened and have received special training to be team members.

Each year a statewide training session is required for CISM team members. Each team member also signs a memorandum of understanding, agreeing to certain responsibilities and renewing his/her commitment to the CISM Program. In addition, each region has quarterly CISM meetings for its team members.

**Q. Are there any clinical advisors for the CISM Program?**

**A.** Jim Clemens, Carolyn Graham, and Lee Ross, selected because of their geographic location and their seniority as team members, advise the CISM Program Director as needed.

**Q. Who are the 6 CISM Regional Coordinators?**

**A.** Lee Ross/Jim McAuley, Region I
Russell Voekler, Washington County
Larry West, Frederick County
Jim Clemens/Jeff Schaffer, Region III
Allen Schauber/Jerry Bennett, Region IV
Carolyn Graham, Region V

**Q. How would I request the CISM Team?**

**A.** 1. Contact the CISM Coordinator in your region or contact SYSCOM (1-800-648-3001) to have a CISM team member call you to discuss your concerns.

*(Continued on page 4)*

# A Message From the MIEMSS Executive Director

*Dr. Robert Bass*

**CRT Program to Continue**

During the past several months in my frequent travels throughout Maryland, I was often asked: "In view of the National Highway Traffic Safety Administration's recommended training standards for Emergency Medical Technician-Paramedic, will Maryland's Cardiac Rescue Technician (CRT) continue to remain an ongoing program?" My answer is a resounding "YES!" The CRT program will continue as an active training and certification path for those Maryland prehospital care providers who wish to remain at an intermediate provider level.

Certainly the EMT-P program is recognized as the "gold standard" for prehospital care, and I (along with my staff) will be continually developing methods and identifying resources to assist those intermediate providers throughout the state who wish to attain EMT-P certification.

**EMT-Basic Update**

Regarding the current status for the design and implementation of the Emergency Medical Technician-Basic (EMT-B) curriculum, the Statewide EMS Advisory Council's (SEMSAC) Education and Training Committee has recently appointed a Basic Life Support Subcommittee. The subcommittee's first task was to evaluate the new EMT-B curriculum component of the National EMS Education and Practice Blueprint, which developed as a result of the NHTSA 1990 Consensus Workshops on EMS Training Programs. The subcommittee is also responsible for developing a cohesive and customized EMT-B curriculum for implementation within the state of Maryland.

The essential differences between the current Maryland EMT-A curriculum and the new EMT-B curriculum are as follows:

1. The requirement of CPR as a prerequisite to the course. Given the constraints of the curriculum regarding total hours, it was not feasible to have CPR instruction in the program.
2. The addition of AED training;
3. The addition of a clinical internship;
4. The deletion of training regarding medical terminology;
5. The addition of training regarding assisting the patient with the prescribed self-administered medications of nitroglycerin, inhaled bronchodilators, or autoinjectors, such as EpiPen;
6. The addition of training regarding the administration of charcoal, ipecac, and oral glucose. Ipecac will be administered under physician or Poison Center direction only.

There is flexibility within the model curriculum for each state to delete any or all of the items above or add any item it may feel necessary. To this end the subcommittee discussed the possible addition of infectious disease issues, Hazmat awareness, IV maintenance, and airway adjuncts. The subcommittee also discussed the additional program requirements of on- and off- line medical direction.

The Maryland EMT-B curriculum draft contains approximately 125 course hours, including a clinical/field 10-hour internship.

As the subcommittee continues to refine the curriculum through statewide consensus and in conjunction with the Maryland Fire and Rescue Institute and MIEMSS, a limited pilot testing of the Maryland EMT-B curriculum is slated to begin in the Fall of 1996.

◆ *Robert R. Bass, MD, FACEP*

## Maintenance of MD-3 ECG Monitor/Defibrillator Units Discontinued

Replacement parts of MD-3 ECG Monitor/Defibrillator Units are no longer available from the manufacturer, Datascope. As a result, maintenance on these units must be discontinued on July 1, 1995. Battery replacement will also be discontinued at this time. Units presently in service should be returned to MIEMSS, EMS Communications Engineering Services for replacement.

EMS Communications must remove parts from old MD-3s to keep existing units repaired.

Please call 410-328-3668 for additional information.

◆ *Gene Bidun*
*EMS Communications Engineering Services*

## MIEMSS Can Verify Prehospital Certifications

The MIEMSS Office of Education and Certification (410-706-3666) will verify that a prehospital care provider has a current, valid Maryland certification at the First Responder, EMT-A, CRT, or EMT-P level of care. Those who are employing prehospital care providers either in paid positions or as volunteers are urged to verify the certification of all applicants. In the past, there have been cases of applicants presenting photocopies of falsified certification cards, usually showing an altered level of certification or certification date. All employers of prehospital care providers are reminded that allowing someone to function at a level for which he/she is not certified is putting patients at risk.

# PRMC Emergency Physicians Board-Certified

All seven emergency physicians in practice with Emergency Services Associates at Peninsula Regional Medical Center (PRMC) are now certified by specialty boards in emergency medicine.

According to PRMC President Dan Akin, "Peninsula Regional is one of the few institutions in the United States and the only one on the Eastern Shore to have all certified emergency physicians."

Board certification is a further mark of excellence which physicians may seek after completing accredited residency training. The certification examination, a comprehensive assessment of competence in emergency medicine, is offered by the American Board of Emergency Medicine and the American Board of Osteopathic Emergency Medicine.

"Once a physician passes both the oral and written segments of the exam, he or she has fulfilled the requirements for board certification," said David A. Foley, MD, medical director and chief of PRMC's department of emergency services, who is also the Region IV Medical Director. "Recertification is required every 10 years."

Two emergency physicians have also been elected to Fellow status in the American College of Emergency Physicians, a governing body which promotes and ensures quality in emergency medicine. This honor is bestowed by the college in recognition of outstanding clinical, managerial, and academic achievement by emergency physicians.

About 50 percent of the emergency physicians in the United States are board certified. However, more hospitals and regulatory organizations are requiring certification for quality assurance.

*Board-certified emergency physicians at PRMC are left to right, seated: Dr. James O'N. Burns, Dr. David A. Foley, chief, and Dr. Walter D. Gianelle; standing: Dr. Pamela J. Zorn, Dr. Jack P. Powell, ass't. chief, and Dr. Randall O. Garriott. Not shown is Dr. David H. Johnson.*

# CISM Program

*(Continued from page 2)*

2. After being notified, a CISM regional coordinator will call you to assess the specific needs and set a time and place for the defusing or debriefing. He/she will also ask to be assigned one contact person from the group requesting the CISM team.

3. The CISM regional coordinator will then contact the appropriate number of team members needed, usually those who are geographically the closest to the incident. One team member is appointed team leader.

4. The team leader confirms the time and place with the contact person and gathers any additional information that is needed.

5. Following the defusing or debriefing, the team leader calls the contact person within 48 hours to assess the effectiveness of the session and follow-up on any referrals.

**Q. For additional information on the CISM Program, whom should I contact?**

**A.** Call the CISM Program at MIEMSS and ask for Craig Coleman (410-706-3666).

◆ *Beverly Sopp*

## Reminder to CRTs Regarding ET Training

All CRTs must have completed an Endotracheal Intubation (ET) training program by July 1, 1995. In 1992, it was determined by the Board of Physician Quality Assurance that the transition of all CRTs to CRTs with ET skills should be completed within three years. July 1 also marks the date that esophageal obturator airways (EOAs) will be removed from all Maryland ambulances.

EMS: We're There for Life

# FACT SHEET

Emergency Medical Services Week in Maryland
May 14 - 20, 1995

## EMS: We're There for Life

This national theme for EMS Week 1995 emphasizes that skilled and dedicated EMS providers stand ready to give life-saving assistance whenever and wherever it is needed. EMS providers are available 24 hours a day, 7 days a week, 52 weeks a year.

## EMS Week Goals and Activities

The goals of EMS Week include:

- Educate the public about the EMS System and when it should be used.
- Stress the importance of the role that members of the public play in recognizing and responding to medical emergencies.
- Offer information about CPR and basic first aid.
- Encourage the prevention of illness and injury.
- Show appreciation for the contribution of every member of the EMS team in Maryland.

Throughout the State, EMS providers are planning local activities incorporating many of the goals above. For information about EMS activities in your area, contact your regional administrator.

In previous years, activities have ranged from open houses, equipment displays, automobile extrications, and skills demonstrations to blood pressure screenings, bike rodeos, CPR classes, and poster, esssay, and coloring contests. In addition, many hospitals held appreciation dinners or picnics to honor prehospital providers in their areas.

A statewide awards reception announcing Maryland's "Stars for Life" will be held May 15. At this time, MIEMSS will honor EMS personnel for outstanding performance in delivering prehospital emergency care. Non-EMS individuals will also be recognized for their roles in providing life-saving care. In addition, special awards will be given to the EMS Physician of the Year; the medical facility that gave outstanding support to prehospital care providers; an outstanding injury prevention program; an EMS innovator; and an individual with lifetime service in EMS.


## EMS Regional Offices in Maryland

**REGION I**
- Allegany and Garrett counties
- Region I Office in Grantsville, 301-895-5934

**REGION II**
- Frederick and Washington counties
- Region II Office in Hagerstown, 301-791-2366 or 416-7249

**REGION III**
- Baltimore City and Anne Arundel, Baltimore, Carroll, Harford, and Howard counties
- Region III Office at MIEMSS in Baltimore, 410-706-3996

**REGION IV**
- Caroline, Cecil, Dorchester, Kent, Queen Anne's, Somerset, Talbot, Wicomico, and Worcester counties
- Region IV Office in Easton 410-822-1799

**REGION V**
- Calvert, Charles, Montgomery, Prince George's, and St. Mary's counties
- Region V Office in College Park, 301-474-1485


*EMS Day 1994 at Baltimore's Inner Harbor.*

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# Maryland EMS Statistics

**Maryland-Certified Prehospital EMS Providers (March 1995)**

| | |
|---|---|
| • First Responder | 16,179 |
| • EMT-A | 15,092 |
| • CRT | 1,139 |
| • EMT-P | 1,104 |
| TOTAL | 33,514 |

**Emergency Care Hospitals (March 1995)**

- 49 Emergeny Departments
- 9 Trauma Centers
- 20 Specialty Referral Centers

**9-1-1 Centers**

- In Baltimore City and each of Maryland's 23 counties
- More than 500,000 calls in FY 1994

**Transports in Maryland***

| | | |
|---|---|---|
| • Injuries | 88,566 | (36.5%) |
| • Medical Emergencies | 154,201 | (63.5%) |
| TOTAL | 242,767 | |

**Top 10 Injuries in Patients Transported***

| | | |
|---|---|---|
| • Motor Vehicle Crash | 22,267 | (25.1%) |
| • Falls | 21,875 | (24.7%) |
| • Beatings | 5,367 | (6.1%) |
| • Sports/Rec. | 4,043 | (4.6%) |
| • Pedestrian | 2,522 | (2.8%) |
| • Industrial | 2,319 | (2.6%) |
| • Gunshot Wounds | 1,728 | (2.0%) |
| • Stab Wounds | 1,205 | (1.4%) |
| • Burn | 1,160 | (1.3%) |
| • Bikes | 1,150 | (1.29%) |

**Top 12 Medical Emergencies of Patients Transported***

| | | |
|---|---|---|
| • Myocardial Infarction | 17,411 | (6.7%) |
| • Seizure | 11,161 | (4.3%) |
| • Diabetes | 10,443 | (4.0%) |
| • Asthma | 7,844 | (3.0%) |
| • Congestive Heart Failure | 6,899 | (2.7%) |
| • Chronic Obstruction Pulmonary Disease | 6,498 | (2.5%) |
| • Cerebral Vascular Accident | 6,134 | (2.4%) |
| • OB/GYN | 5,236 | (2.0%) |
| • Overdose | 5,155 | (1.9%) |
| • GI | 4,661 | (1.8%) |
| • Cardiopulmonary Arrest | 3,870 | (1.5%) |
| • Behavioral | 3,356 | (1.3%) |

**Neonatal Transports (FY 1994)**

| | |
|---|---|
| • Neonatal ambulance | 298 |
| • Helicopter | 137 |
| • Helicopter/ambulance | 7 |
| • 1-Way Ambulance | 3 |
| TOTAL | 445 |

**Med-Evac Helicopter Program (March 1995)**

- 11 helicopters
- 8 bases
- 44 flight paramedics
- 56 pilots
- 3,448 transports from scene of injury last year
- 644 interhospital transports last year

**Commercial Ambulances (March 1995)**

- 44 Licensed Services
- 80 Licensed ALS Ambulances
- 235 Licensed BLS Ambulances

**Maryland Poison Center Calls (Calendar Year 1994)**

- 58,821 total calls
- 23,159 requests for information
- 35,622 calls regarding human exposure to poison

*Sources of Human Exposure Calls*

| | |
|---|---|
| - From general public | 81.2% |
| - From physicians | 15.3% |
| - From prehospital providers, pharmacists | 3.5% |

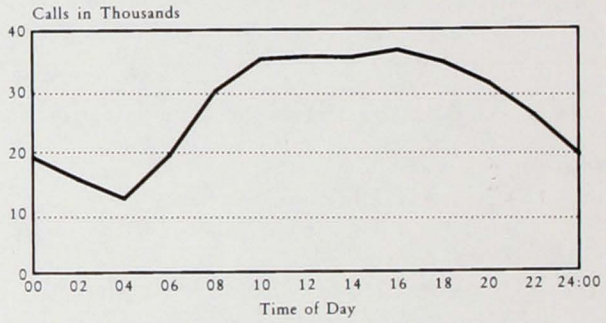
*Age of Patients Exposed to Poison*

| | |
|---|---|
| - Younger than 6 yrs. | 57.6% |
| - 6-12 yrs. | 5.4% |
| - 13-19 yrs. | 7.0% |
| - 20-69 yrs. | 24.2% |
| - 70 yrs. and older | 4.3% |

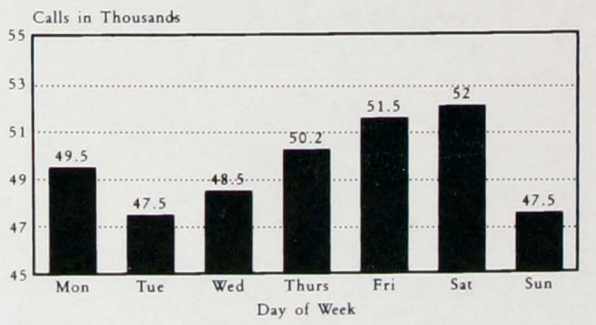
**Transports in Maryland by Age and Type of Emergency***

| Age | Injury | Medical |
|---|---|---|
| 1-30 days | 92 (0.1%) | 506 (0.3%) |
| 30d-5 yrs. | 3,263 (3.7%) | 4,161 (2.6%) |
| 6-15 yrs. | 8,031 (9.1%) | 4,892 (3.1%) |
| 16-60 yrs. | 54,235 (61.2%) | 68,685 (44.3%) |
| 60+ yrs. | 17,453 (19.7%) | 62,535 (40.4%) |

## EMS Demand in Maryland By Time of Day*




## EMS Demand in Maryland By Day of Week*




* Based on MAIS FY 1994 data that do not include Montgomery and Prince George's counties.

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# New EMS Palliative Care/DNR Protocol Approved

## *Will Replace Existing Hospice Protocol*

The Maryland EMS Palliative Care/Do-Not-Resuscitate (DNR) Program has been approved by the Board of Physician Quality Assurance and will be going into effect as protocol for ALS and BLS providers July 1, 1995. From July 1, 1995 to September 30, 1995 hospice cards issued under the previous Hospice/EMS Palliative Care Protocol will continue to be honored. During this period the Hospice programs throughout the state will be working with their patients to convert from the current hospice cards to the EMS Palliative Care/DNR Order forms and bracelets. Any new patients will receive EMS Palliative Care/DNR Order forms and bracelets starting July 1, 1995 and no new hospice cards will be issued after July 1, 1995. As of October 1, 1995, only the EMS Palliative Care/DNR Order forms and bracelets will be accepted to initiate the EMS Palliative Care/DNR Protocol.

**Reasons for DNR Program**

Over the past decade, the issue of a patient's right to self determination – the ability to make health care decisions for oneself – has taken on an increasingly important role in our society and within the EMS community. The legal framework upon which emergency medical service has traditionally been rendered relied heavily on the concept of implied consent. That is, when a patient is unable to provide expressed consent to care, such as when unconscious as a result of serious illness or traumatic injury, it is assumed that the patient would want life-saving treatment.

In certain cases, this benevolent assumption is incorrect. There are numerous legal means by which patients can control the medical care they receive if they are unable to participate in the decision-making process. Advance directives such as "living wills" provide a prospective means by which individuals can specify the kind of medical care they desire under specific circumstances if, in the future, they are unable to do so themselves. For example, individuals with incurable and degenerative diseases may specify the care desired if they lapse into a comatose or non-communicative state. "Durable powers of attorney for health care" make it possible for individuals to appoint a trusted person to make health care decisions for them if they are unable to do so. For example, perfectly healthy adults may avail themselves of this provision well in advance of an unforeseen event, such as a traumatic injury, that would render them in a persistent vegetative state.

While such legal instruments serve patients well in clinical environments, they pose practical problems in life-threatening situations when emergency medical services are called for assistance. Living wills, powers of attorney, and other advance directives are often long and complex, and can vary greatly in form and content. There is a very limited amount of time in which EMS personnel must evaluate the situation and take appropriate action. A number of mechanisms have been put in place to make it possible for EMS personnel to respond appropriately to patient wishes regarding health care in emergency situations.

Maryland was one of the earliest states to address this issue when, in 1988, a Hospice/EMS Palliative Care Protocol was adopted. While this protocol has served the citizens of Maryland well, it was limited in its applicability to patients enrolled in established hospice programs. In 1991, the Federal Patient Self-Determination Act was passed which required hospitals and nursing homes that participated in Medicare and Medicaid programs to honor patients' requests regarding end-of-life decisions and to provide patients with information about advance directives. Since that time, more than 20 states have adopted do-not-resuscitate legislation or protocols.

In 1993, the Maryland Legislature, recognizing the limitations of the state's hospice protocol and seeking to clarify existing state law with regard to health care decision issues, enacted the Health Care Decision Act. One provision of the Act called upon MIEMSS to work with the Board of Physician Quality Assurance and other key groups and individuals within the state to develop an EMS Palliative Care/DNR Protocol. This protocol greatly expands access to palliative care and do-not-resuscitate orders within Maryland. More importantly, it enables EMS providers to honor patients' wishes to the greatest extent possible with dignity, humanity, and compassion.

**Differences Between Hospice & DNR Programs**

The Maryland EMS Palliative Care/DNR Program is similar to the Hospice/EMS Palliative Care Program, which it will eventually replace; however, there are important differences. The medical protocol portion is essentially the same for both programs except for minor updates to reflect current medical practice and new airway adjuncts.

The procedural aspects of the two protocols differ significantly. Much of the procedural material of the new EMS Palliative Care/DNR Program has been drawn from, and is set in, the Health Care Decision Act itself. For example, the new protocol calls for an EMS Palliative Care/DNR Order form or an optional bracelet, rather than the hospice card referred to in the current protocol. The EMS Palliative Care/DNR Order is a physician's medical order that appears on a standard form that will be the same throughout the state. This will make rapid identification easier regardless

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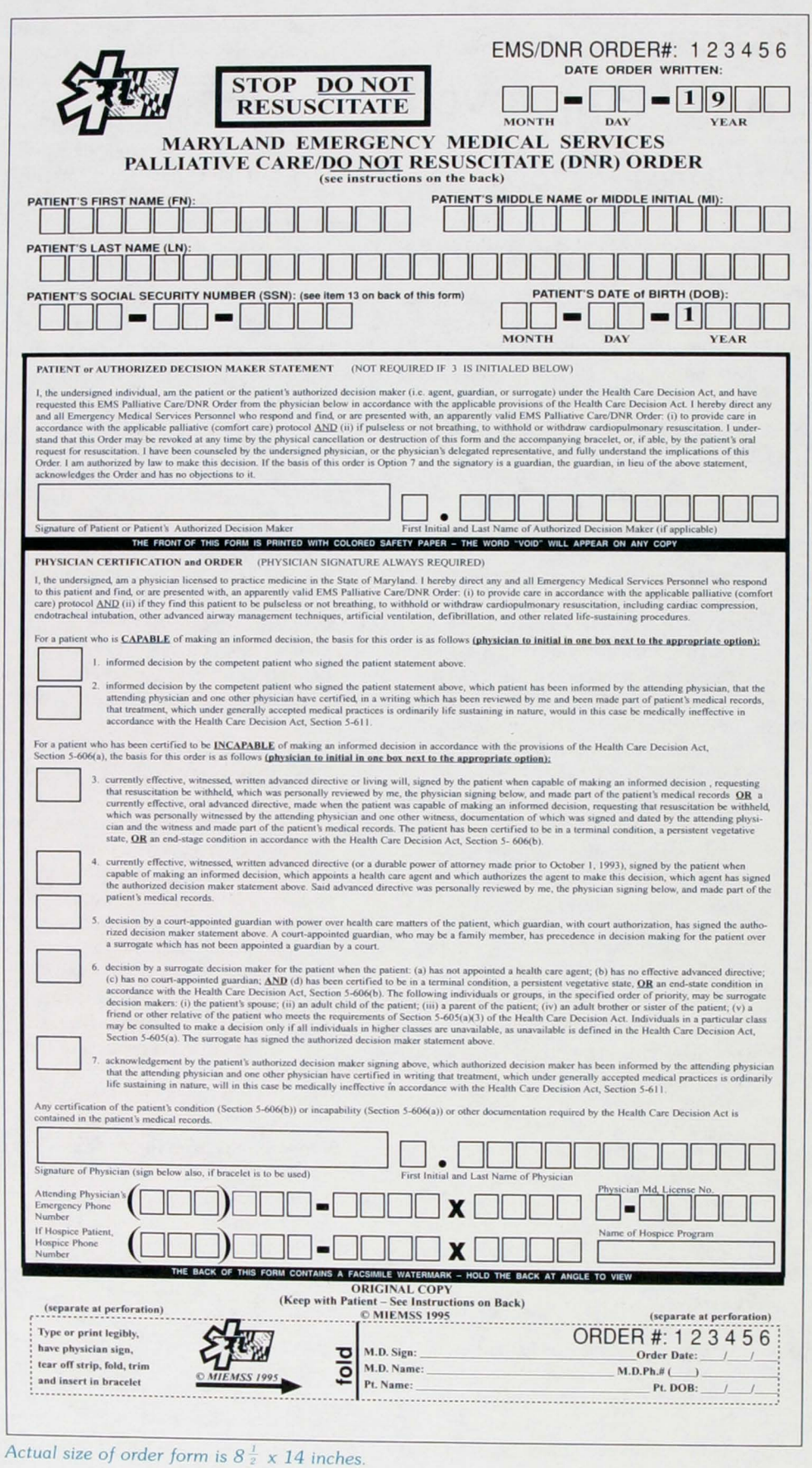


EMS/DNR ORDER#: 1 2 3 4 5 6

STOP DO NOT RESUSCITATE

DATE ORDER WRITTEN: ☐☐ - ☐☐ - 1 9 ☐☐
MONTH DAY YEAR

MARYLAND EMERGENCY MEDICAL SERVICES
PALLIATIVE CARE/DO NOT RESUSCITATE (DNR) ORDER
(see instructions on the back)

PATIENT'S FIRST NAME (FN): ☐☐☐☐☐☐☐☐☐☐☐☐

PATIENT'S MIDDLE NAME or MIDDLE INITIAL (MI): ☐☐☐☐☐☐☐☐☐☐☐☐

PATIENT'S LAST NAME (LN): ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

PATIENT'S SOCIAL SECURITY NUMBER (SSN): (see item 13 on back of this form) ☐☐☐ - ☐☐ - ☐☐☐☐

PATIENT'S DATE of BIRTH (DOB): ☐☐ - ☐☐ - 1 ☐☐
MONTH DAY YEAR

PATIENT or AUTHORIZED DECISION MAKER STATEMENT (NOT REQUIRED IF 3 IS INITIALED BELOW)

I, the undersigned individual, am the patient or the patient's authorized decision maker (i.e. agent, guardian, or surrogate) under the Health Care Decision Act, and have requested this EMS Palliative Care/DNR Order from the physician below in accordance with the applicable provisions of the Health Care Decision Act. I hereby direct any and all Emergency Medical Services Personnel who respond and find, or are presented with, an apparently valid EMS Palliative Care/DNR Order: (i) to provide care in accordance with the applicable palliative (comfort care) protocol AND (ii) if pulseless or not breathing, to withhold or withdraw cardiopulmonary resuscitation. I understand that this Order may be revoked at any time by the physical cancellation or destruction of this form and the accompanying bracelet, or, if able, by the patient's oral request for resuscitation. I have been counseled by the undersigned physician, or the physician's delegated representative, and fully understand the implications of this Order. I am authorized by law to make this decision. If the basis of this order is Option 7 and the signatory is a guardian, the guardian, in lieu of the above statement, acknowledges the Order and has no objections to it.

Signature of Patient or Patient's Authorized Decision Maker

☐. ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐
First Initial and Last Name of Authorized Decision Maker (if applicable)

THE FRONT OF THIS FORM IS PRINTED WITH COLORED SAFETY PAPER – THE WORD "VOID" WILL APPEAR ON ANY COPY

PHYSICIAN CERTIFICATION and ORDER (PHYSICIAN SIGNATURE ALWAYS REQUIRED)

I, the undersigned, am a physician licensed to practice medicine in the State of Maryland. I hereby direct any and all Emergency Medical Services Personnel who respond to this patient and find, or are presented with, an apparently valid EMS Palliative Care/DNR Order: (i) to provide care in accordance with the applicable palliative (comfort care) protocol AND (ii) if they find this patient to be pulseless or not breathing, to withhold or withdraw cardiopulmonary resuscitation, including cardiac compression, endotracheal intubation, other advanced airway management techniques, artificial ventilation, defibrillation, and other related life-sustaining procedures.

For a patient who is CAPABLE of making an informed decision, the basis for this order is as follows (physician to initial in one box next to the appropriate option):

☐ 1. informed decision by the competent patient who signed the patient statement above.

☐ 2. informed decision by the competent patient who signed the patient statement above, which patient has been informed by the attending physician, that the attending physician and one other physician have certified, in a writing which has been reviewed by me and been made part of patient's medical records, that treatment, which under generally accepted medical practices is ordinarily life sustaining in nature, would in this case be medically ineffective in accordance with the Health Care Decision Act, Section 5-611.

For a patient who has been certified to be INCAPABLE of making an informed decision in accordance with the provisions of the Health Care Decision Act, Section 5-606(a), the basis for this order is as follows (physician to initial in one box next to the appropriate option):

☐ 3. currently effective, witnessed, written advanced directive or living will, signed by the patient when capable of making an informed decision , requesting that resuscitation be withheld, which was personally reviewed by me, the physician signing below, and made part of the patient's medical records OR a currently effective, oral advanced directive, made when the patient was capable of making an informed decision, requesting that resuscitation be withheld, which was personally witnessed by the attending physician and one other witness, documentation of which was signed and dated by the attending physician and the witness and made part of the patient's medical records. The patient has been certified to be in a terminal condition, a persistent vegetative state, OR an end-stage condition in accordance with the Health Care Decision Act, Section 5- 606(b).

☐ 4. currently effective, witnessed, written advanced directive (or a durable power of attorney made prior to October 1, 1993), signed by the patient when capable of making an informed decision, which appoints a health care agent and which authorizes the agent to make this decision, which agent has signed the authorized decision maker statement above. Said advanced directive was personally reviewed by me, the physician signing below, and made part of the patient's medical records.

☐ 5. decision by a court-appointed guardian with power over health care matters of the patient, which guardian, with court authorization, has signed the authorized decision maker statement above. A court-appointed guardian, who may be a family member, has precedence in decision making for the patient over a surrogate which has not been appointed a guardian by a court.

☐ 6. decision by a surrogate decision maker for the patient when the patient: (a) has not appointed a health care agent; (b) has no effective advanced directive; (c) has no court-appointed guardian; AND (d) has been certified to be in a terminal condition, a persistent vegetative state, OR an end-state condition in accordance with the Health Care Decision Act, Section 5-606(b). The following individuals or groups, in the specified order of priority, may be surrogate decision makers: (i) the patient's spouse; (ii) an adult child of the patient; (iii) a parent of the patient; (iv) an adult brother or sister of the patient; (v) a friend or other relative of the patient who meets the requirements of Section 5-605(a)(3) of the Health Care Decision Act. Individuals in a particular class may be consulted to make a decision only if all individuals in higher classes are unavailable, as unavailable is defined in the Health Care Decision Act, Section 5-605(a). The surrogate has signed the authorized decision maker statement above.

☐ 7. acknowledgement by the patient's authorized decision maker signing above, which authorized decision maker has been informed by the attending physician that the attending physician and one other physician have certified in writing that treatment, which under generally accepted medical practices is ordinarily life sustaining in nature, will in this case be medically ineffective in accordance with the Health Care Decision Act, Section 5-611.

Any certification of the patient's condition (Section 5-606(b)) or incapability (Section 5-606(a)) or other documentation required by the Health Care Decision Act is contained in the patient's medical records.

Signature of Physician (sign below also, if bracelet is to be used)

☐. ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐
First Initial and Last Name of Physician

Attending Physician's Emergency Phone Number (☐☐☐)☐☐☐-☐☐☐☐ x ☐☐☐☐

Physician Md. License No. ☐-☐☐☐☐☐

If Hospice Patient, Hospice Phone Number (☐☐☐)☐☐☐-☐☐☐☐ x ☐☐☐☐

Name of Hospice Program

THE BACK OF THIS FORM CONTAINS A FACSIMILE WATERMARK – HOLD THE BACK AT ANGLE TO VIEW

ORIGINAL COPY
(Keep with Patient – See Instructions on Back)
© MIEMSS 1995

(separate at perforation)

Type or print legibly, have physician sign, tear off strip, fold, trim and insert in bracelet

© MIEMSS 1995

fold

(separate at perforation)

ORDER #: 1 2 3 4 5 6

M.D. Sign: _____ Order Date: ___/___/___

M.D. Name: _____ M.D.Ph.# (___) _____

Pt. Name: _____ Pt. DOB: ___/___/___

*Actual size of order form is 8 $\frac{1}{2}$ x 14 inches.*

*(Continued from page 7)*

of where EMS personnel practice within the state. (A reduced copy of the standard Order form and samples of the bracelets are reproduced here and on page 9 so that you can become familiar with them.)

**DNR Implementation Procedure**

An informational booklet describing the program will be available for training beginning May 23, 1995. The Order forms and bracelets will be distributed to physicians, hospitals, nursing homes, hospices, and other medical facilities upon request. Since these Orders will always require a physician's signature to be valid, and counseling and support are vital to the decision-making process, the forms themselves will not be distributed directly to the general public. Individuals interested in the EMS Palliative Care/DNR Program should contact their physician or medical facility for additional information and instructions on how to go about getting an EMS Palliative Care/DNR Order.

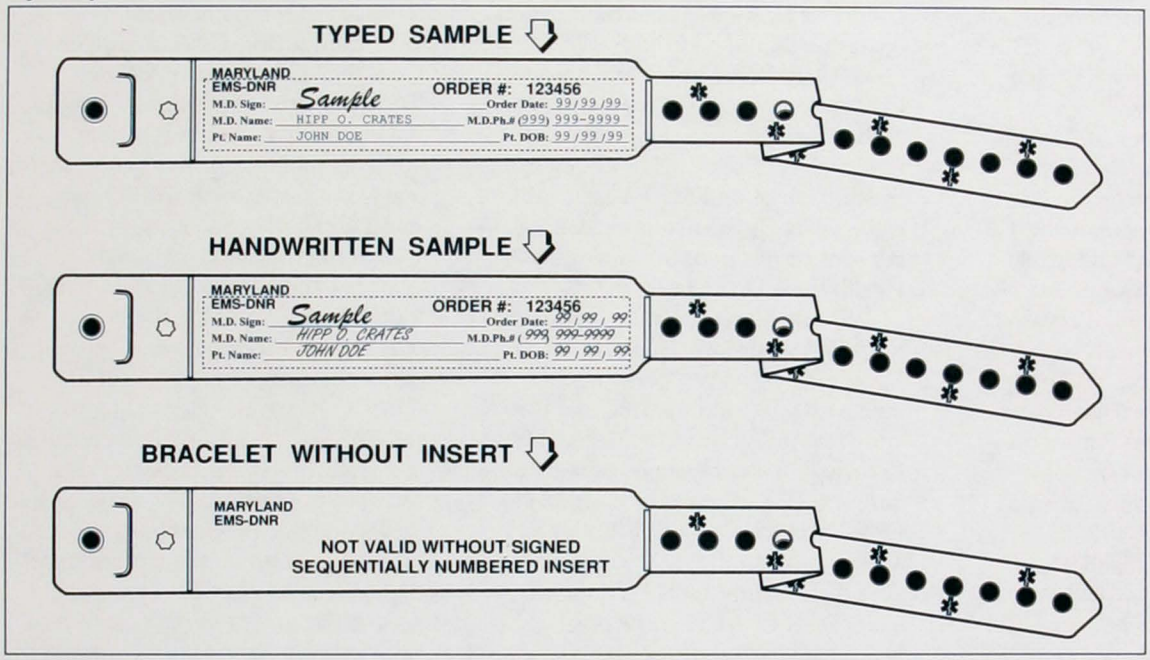
A patient or a patient's authorized decision maker contemplating an EMS Palliative Care/DNR Order should review the Health Care Decision Act and consult with the patient's attending physician and legal advisor, in order to understand the applicable provisions of the Act, to determine qualification, and to execute those legal instruments, permitted under the Act, that may be required prior to the issuance of an EMS Palliative Care/DNR Order. A copy of the Act is included in the informational booklet. Condensed instructions on how to complete the EMS Palliative Care/DNR Order can be found on the back of the DNR Order form. Patients or their authorized decision makers may want to consider hospice or home health care for support and counseling related to do-not-resuscitate orders.

*(Continued on page 9)*

*(Continued from page 8)*

**DNR Order Form & Bracelet**

The EMS Palliative Care/DNR Order form itself consists of four parts. The actual form will be 8 $\frac{1}{2}$ x 14 inches in size. The first portion includes information required to identify the patient and the effective date of the Order. The second portion is confirmation or acknowledgment by the patient or the patient's authorized decision maker that Palliative Care/DNR status is being requested for the patient. This section must be signed by the patient or the patient's authorized decision maker unless a valid oral or written advance directive was made previously by the patient, when the patient was competent. When a valid, effective advance directive exists, the Order need only be signed by the patient's physician. The third portion is the physician certification portion which must always be signed by a Maryland licensed physician in order for the form to be valid. This portion requires the physician to identify which of seven provisions of the Health Care Decision Act a patient qualifies under in order to obtain an EMS Palliative Care/DNR Order. It also provides emergency telephone numbers for the signing physician and, if the patient is enrolled in a hospice, the hospice support number. These phone numbers are available to EMS personnel should the physician or hospice need to be contacted regarding the patient. The fourth portion of the form is the tear-off insert to the optional Palliative Care/DNR bracelets.




*Bracelets are reduced for inclusion into this article. Actual size accommodates insert that is correctly spaced for typewriting.*

The EMS Palliative Care/DNR Order form and bracelet are designed to be distinctive and readily recognizable. A number of design features have been incorporated to reduce the possibility that the form or bracelet can be intentionally or inadvertently misused. The Order consists of an original and a copy. The original of the form is printed on tamper-resistant paper and sequentially numbered. At the bottom of the form is a detachable strip for insertion in a hospital-style bracelet. The bracelet is imprinted with the Star of Life and the moniker "MARYLAND EMS-DNR." The copy is readily identifiable as a copy, and therefore not valid as an EMS Palliative Care/DNR Order. The copy folds into a preaddressed mailer to be returned to MIEMSS for quality assurance purposes. The bracelets are designed to be moisture-resistant and durable. The bracelet insert contains the same sequential number as the form and also contains a subset of the patient information found on the form. A bracelet alone, without an appropriately completed, sequentially numbered insert is not a valid DNR order.

If the optional bracelet is to be used, the insert at the bottom of the EMS Palliative Care/DNR Order must be completed and signed by the physician issuing the Order. An original Order form, or a bracelet with an original insert, has the same effect with respect to initiating the EMS Palliative Care/DNR Protocol. Both need not be present. However, use of the bracelet is optional. The bracelet may be worn about the wrist or hung from a necklace. The wrist location is preferred. EMS personnel are trained to routinely check a patient's wrists and neck upon initial assessment for signs of circulation and the presence of medical alert devices.

**DNR Protocol & Prehospital Care**

If an apparently valid EMS Palliative Care/DNR Order form or bracelet **is presented** to EMS personnel **upon their arrival**, they will initiate the palliative (comfort care) protocol, that allows for comfort-giving care, rather than resuscitation.

If an original EMS Palliative Care/DNR Order form or bracelet with original insert from Maryland or another state **is not present** and an appropriate oral DNR order **is not received** by EMS personnel directly from a physician, EMS personnel responding on an ambulance (whether volunteer, commercial, or governmental) or as part of an EMS team, are required by their standing medical protocols to initiate and continue cardiopulmonary resuscitation,

*(Continued on page 10)*

*(Continued from page 9)*
including cardiac compression and, depending on their level of certification, licensing, or registration, to perform endotracheal intubation, other advanced airway management techniques, artificial ventilation, defibrillation, and other related life-sustaining procedures. No other written form of DNR Order may be followed by EMS personnel in the prehospital or interfacility setting (other than hospice cards through September 30, 1995). If a valid EMS Palliative Care/DNR Order is located after resuscitation has begun, EMS personnel may withdraw resuscitative efforts and invoke the palliative (comfort care) protocol which requires that standard comfort care measures be provided. Ambulance personnel cannot honor specific instructions in advance directives (for example, wants intubation but not CPR) that do not conform to the palliative (comfort care) protocol.

If there is reasonable doubt about the identity of the patient or the validity of an EMS Palliative Care/DNR Order, EMS providers will err on the side of attempting resuscitation. EMS providers acting in good faith are protected from criminal prosecution, civil liability, or administrative action when withholding or withdrawing resuscitation in accordance with the Health Care Decision Act.

An EMS Palliative Care/DNR Order may be revoked at any time by the patient's request for resuscitation made directly to responding EMS personnel **or** by the physical cancellation or destruction of all EMS Palliative Care/DNR Order forms and bracelets with the consent of the patient or the authorized decision maker signing the EMS Palliative Care/DNR Order. Destruction of an EMS Palliative Care/DNR Order or bracelet without consent carries penalties under the Health Care Decision Act.

There is no expiration date for EMS Palliative Care/DNR Orders in Maryland. However, patients, their authorized decision makers, and their attending physicians are encouraged to review the continuing need, desire, and qualification for an issued EMS Palliative Care/DNR Order at least annually.

An **original** EMS Palliative Care/DNR Order form **or** bracelet with **original** insert from Maryland or another state must be present to invoke the palliative (comfort care) protocol. If there is a need to have an EMS Palliative Care/DNR Order in more than one location and it is not practical for the EMS Palliative Care/DNR Order form or bracelet to accompany the patient, more than one original EMS Palliative Care/DNR Order must be issued. Copies will not be honored.

**Evaluating DNR Program**

While the Hospice/EMS Palliative Care Program was successful in meeting the needs of those patients that had access to hospice care, most of the information we have about the effectiveness of the program in meeting the needs of patients and EMS providers is anecdotal. With the EMS Palliative Care/DNR Program, we are asking for a data processing copy of the DNR Order to be returned to MIEMSS. The information contained on the form will be protected as a confidential record. The purpose in collecting the information is to evaluate the frequency of use of the EMS Palliative Care/DNR Program and to assess the quality of the program so that we can make future improvements to meet evolving needs. To our knowledge we are the first state to attempt to close the feedback loop prospectively by providing a means to evaluate the effectiveness of this program.

**Additional DNR Information**

Questions or comments regarding EMS Palliative Care/DNR Orders may be forwarded to MIEMSS by writing to the MIEMSS EMS Palliative Care/DNR Program Office, 636 West Lombard Street, Baltimore, Maryland 21201-1528 or by calling 410-706-4367 (4DNR). Single copies or larger quantities of the EMS Palliative Care/DNR Order forms and bracelets may be acquired free of charge from this Office by physicians, hospitals, hospices, nursing homes, and other licensed health care or domiciliary facilities. Recipients may not charge patients for the EMS Palliative Care/DNR Order forms and bracelets provided by MIEMSS.

◆ *George Smith*
*DNR Program Coordinator*

## *DNR Program Implementation Dates*

Implementation of the EMS Palliative Care/Do-Not-Resuscitate (DNR) Program will be phased in through a series of activities. On April 22, 1995 Assistant Attorney General Sarah Sette will kick off the implementation with a presentation on the EMS Palliative Care/DNR Program at the EMS Care '95 Conference in Greenbelt, Maryland. Ms. Sette is the Assistant AG assigned to MIEMSS and a member of the DNR Program development team. During the week of May 23-29 train-the-trainer sessions will be held in each of the five regions to accommodate the EMS instructors. On May 29, 1995, training of EMS and health care personnel will begin. Continuing education credit will be awarded to EMS providers for attending training on this program. In addition to the program booklet, MIEMSS will make available a training video and training objectives to assist training personnel. On June 26, 1995, DNR Order forms and bracelets will be released to physicians, hospitals, nursing homes, hospices, and other licensed health care facilities. On July 1, 1995, MIEMSS will release information to the public.

For copies of the program booklet, questions about protocol, or to schedule training opportunities, contact your MIEMSS Regional Office.

| | |
|---|---|
| Region I (Allegany and Garrett Counties) | (301) 895-5934 |
| Region II (Frederick and Washington Counties) | (301) 791-2366 |
| Region III (Baltimore Metropolitan Area) | (410) 706-3996 |
| Region IV (Eastern Shore) | (410) 822-1799 |
| Region V (Washington Metropolitan Area) | (301) 474-1485 |

# May Is Bicycle Safety Month

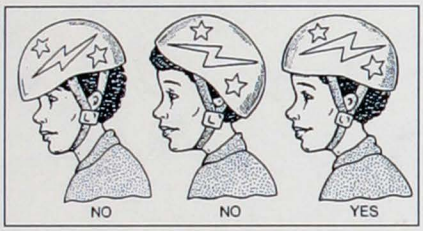
## *Law Will Require Bike Helmets in Maryland*

**The following information on bike helmets and safety may be reproduced and distributed as a handout.**

Legislation recently passed both the House and Senate requiring a person under the age of 16 who is riding a bicycle or is a passenger on a bicycle to wear a helmet that meets or exceeds one of three standards for helmets. There are currently three nationally recognized standards for bicycle helmets: SNELL - Snell Memorial Foundation; ANSI - American National Standards Institute; and ASTM - American Society for Testing and Materials. Those who do not obey the law would receive a warning from the police and printed educational information about bike helmet use. Failure to wear a bike helmet would be a civil offense. The new legislation will not apply on the Ocean City boardwalk and does not change the existing laws in Montgomery, Howard, or Allegany counties.

The necessity of wearing a helmet while riding a bike--for everyone, including adults--was stressed during the legislative session. A bicycle helmet can make the difference between a survivable injury and an injury that results in permanent disability or death from a head injury. Use of an approved bike helmet can prevent three out of four cyclist deaths and serious head injuries. The term "head injury" refers to the blunt and tearing injuries to the brain that result in cognitive, physical, psychosocial, and

*(Continued on page 12)*




*Art Courtesy of Maryland SAFEKIDS Coalition.*

*Art by Maryland DOT. Used with permission.*

### Bike Safety Tips

The Maryland Department of Transportation Bicycle Affairs Office has published "Tips for Safe Bicycling," which emphasizes:

- Wear a helmet with a hard outer shell.
- Ride a proper sized bike.
- Obey all traffic signs and signals.
- Ride with traffic (walk against traffic).
- Keep to the right side of traffic and in a single file.
- Use hand signals for any movement in traffic.
- Be bright at night - wear bright colors and reflectors.
- Be cautious of storm drains, wet pavement, and gravel.
- Watch out for driveways and parked cars - especially people opening car doors.
- Stop and check for traffic before entering any roadway.
- Be aware that dogs and small animals may chase the wheels.
- Never carry a passenger on a one-seater bike.

*Children at Howard County's Rockburn Elementary School participate in a bike safety program conducted by John Overstreet, Safety Chairman for the Baltimore Bicycle Club, and sponsored by the Rockburn Elementary School PTA.*

# May Is Bicycle Safety Month

*(Continued from page 11)*

emotional disabilities, many of which are permanent.

Head injuries account for 70-80% of all bicycle deaths, with 70% of bicyclists hospitalized due to head trauma. According to the Centers for Disease Control, nationally there are 600 bicycle-related head injury deaths each year, more than 180,000 emergency department treated bicycle-related head injuries, and 12,000 hospitalizations due to bicycle-related head injuries. Both MIEMSS' Maryland Ambulance Information System (MAIS) data and national data indicate that the age group at highest risk for head injury is between 1 and 16 years, with boys at a greater risk. For every child who died from a bicycle-related injury, an estimated 100 will be hospitalized in Maryland each year.

MIEMSS was among many groups that testified in favor of mandatory bicycle helmet legislation. Based upon review of the MAIS data for fiscal year 1994, unhelmeted bicyclists were found to be five times more likely to sustain head injuries than helmeted bicycle riders (7.2% of helmeted riders sustained head injuries compared to 43.2% of unhelmeted bicycle riders). The higher injury severity classes as determined by patient priority at the scene of the crash were also six times greater for the unhelmeted patient. Another significant piece of information from the MAIS data is that the unhelmeted patients were four times more likely to be taken to a trauma center or specialty center.

A survey conducted by the National SAFEKIDS Campaign found that 73% of parents of children under the age of 15 favor a law requiring mandatory bicycle helmet usage. Bicycle helmets work by absorbing and distributing the energy of impact in a crash before the energy reaches the fragile brain tissues; helmets can reduce the risk of head injury by 85% and the risk of brain injury by almost 90%.

*Article by Cynthia J. Wright-Johnson, MSN, Administrator for Emergency Medical Services for Children Program, MIEMSS; MAIS Data Complied by John New, Director of Quality Management, MIEMSS*

## Bike Safety Grant

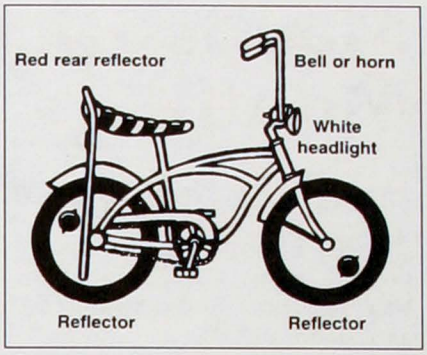
The Division of Injury and Disability Prevention and Rehabilitation (DIDPR) within the Maryland Department of Health and Mental Hygiene was awarded a 3-year (October 1993 through 1996) Statewide Bicycle Safety and Education Grant. The grant has three components: community-based programs implemented by local county health departments, a media campaign in collaboration with Cycle Across Maryland, and a school-based program targeted to fourth-graders.

County health departments that have received funds to implement community-based bike safety and education programs include Cecil, Garrett, Montgomery, and Caroline. It is hoped that other county health departments will also participate. Through cooperation with the Maryland Department of Education, school-based bike safety programs have been implemented into the fourth-grade curriculum in Anne Arundel, Harford, and Cecil counties. Calvert and Frederick counties are the control groups for evaluating the effectiveness of community-based and school-based bike safety programs. As part of the media campaign, a public service announcement, brochures, stickers, and pins were produced and are available by contacting Pam Brown at DIDPR (410-225-5780).

## Basic Bike Safety Equipment

"Wear a bicycle helmet" is probably the most important safety rule when you ride a bike. However, according to the American Automobile Association, many other items (see following list) are also necessary to ensure maximum safety when riding a bicycle.

- helmet - correctly sized and correctly worn
- warning bell or horn
- chain guard
- coaster brake
- reflective devices on front, rear, sides, and pedals
- "day-glo" safety flag
- front light (white)
- rear light (red)
- handle grips
- pants leg clips
- bright or reflective clothing




*Some basic bike safety equipment. Art by Maryland DOT. Used with permission.*

## Fitting the Bicycle to the Child

Under 5 years.....12"or 16" wheel
5 to 7 years.....20" wheel
8 to 10 years.....24" wheel
11 and over.....26" or 27" wheel

# Prehospital Care for the Homeless

You are summoned to a commercial district by a local merchant to help a homeless person who is lying, seemingly helpless, on the sidewalk. When you arrive on the scene, however, you find that the person seems to be alert and oriented, despite the smell of alcohol on his breath. He does not let you treat him at the scene and he refuses to be transported to a hospital. What would be your response in such a situation?

By law, you know that your professional obligation as a prehospital care provider ends when a patient refuses your assistance. So with a clear conscience, you might go on your way, feeling that you've done all you could for that person.

Or did you? You get your answer the next day, when you find out that the same man later died on the street from congestive heart failure.

There is much that prehospital care providers can do for homeless people, even when they at first refuse treatment, says Todd Johnson, assistant rescue chief of the Junior Volunteer Fire Company in Frederick County.

A homeless person might decline treatment or not seek medical attention due to one of the following obstacles, which EMS personnel can play an important role in addressing, says Mr. Johnson.

• First, homeless people may avoid medical care because they are either too ashamed of their general appearance or state of personal hygiene to visit a medical facility, or they may feel too undeserving as human beings to accept medical care.

The social stigma they feel is sometimes reinforced by health care providers if they hold deep-seated negative attitudes toward the homeless, such as: it doesn't really matter what happens to homeless people because they're just no good down-and-outs; helping homeless people is a waste of time because they won't take care of themselves; I'd rather not get close enough to a homeless person to render treatment.

Such attitudes would prevent health care providers from being empathetic to homeless patients, or worse, cause them to show their disgust toward such patients and even to default on their professional obligation to provide adequate care. In one extreme case that occurred in 1991, three members of a New Jersey first aid squad reportedly beat up and then abandoned a retarded homeless man who had called for ambulance service on several previous occasions.

"Apply the Golden Rule" when dealing with homeless people, Mr. Johnson advises. To back himself up, he cites the Brady Emergency Care textbook, which encourages emergency medical personnel to treat their patients as they would members of their own families. That admonition does not contain any exclusions, notes Mr. Johnson.

By letting the Golden Rule guide their interactions with homeless people, health care professionals will be able to establish positive relationships with them, he says. This will tend to break down the social barrier that prevents health care professionals from wanting to provide help, and homeless people from wanting to accept help.

• The second, and painfully obvious, reason that homeless people have for avoiding medical care is they simply can't afford it. Their survival needs for food and shelter take precedence over their less pressing need for health care. Some use their limited financial resources to buy the drugs or alcohol they want to help them escape the shame and depression they feel regarding the condition of their lives.

• Many homeless people lack the education to know how to take care of themselves effectively or are not aware of the medical and social services that are available to them.

Emergency medical personnel can assist by informing homeless patients about programs such as Health Care for the Homeless (HCH). The services provided by HCH programs (which are federally funded) might include routine medical care at a primary care clinic, case management, and medical and social outreach services. Or EMS providers might even take the proactive stance of referring homeless patients to the HCH program, suggests Mr. Johnson, who also coordinates the HCH program for the Frederick Community Action Agency.

When a homeless person is referred to the HCH program, an outreach worker visits that person in the community to make him or her aware of the medical and social services that are available through the HCH program and to encourage him or her to access the services needed.

To be an effective advocate of HCH, however, emergency medical personnel, themselves, must be aware of the benefits of the program. To get the word out to them, Mr. Johnson has developed a seminar, entitled "EMS and the Homeless."

In his presentation, Mr. Johnson states that one of the goals of the HCH program is to provide the medical care to the homeless to prevent their health problems from developing into chronic conditions and continuing to be a barrier to end their homelessness.

"The trend in health care today is toward preventive medicine," notes Mr. Johnson. Although emergency care personnel may find it odd to think of themselves as primary care providers, Mr. Johnson stresses how important a role they can play in promoting that trend.

◆ *Dick Grauel*

# P.G. County Disaster Drill

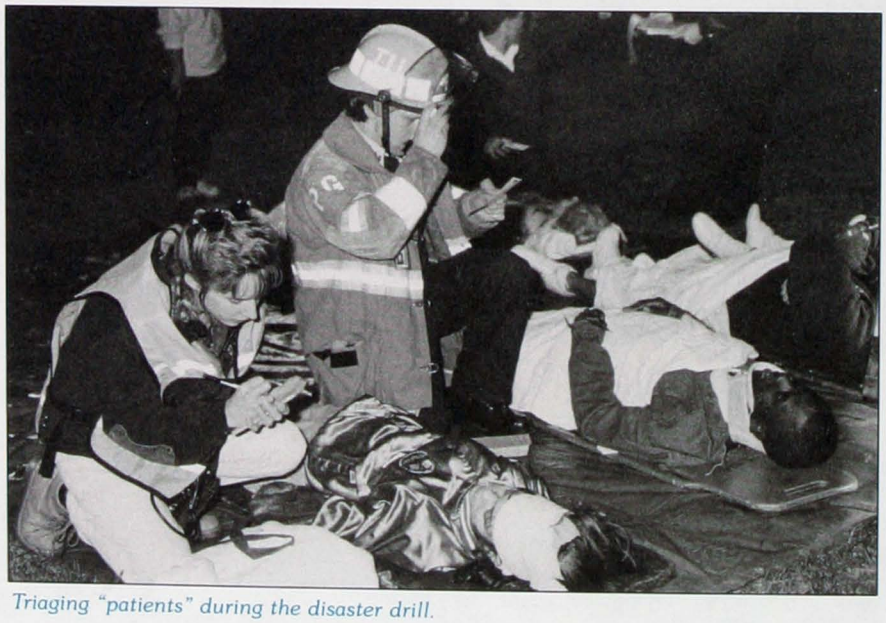
On March 21, 1995, Prince George's County Fire Communications received a call that a plane had crashed in the football field at a local high school. The first arriving EMS units, reporting numerous patients, requested more ground units and two Med-Evac helicopters and alerted the local hospitals.

Fortunately, the above scenario was only a drill. As part of a coordinated effort among Prince George's Hospital Center, Doctors Community Hospital, and Laurel Regional Hospital, along with Prince George's County Fire Department, Maryland State Police Trooper 8, and U.S. Park Police Eagle 1, a disaster drill was conducted to test the disaster preparedness of these agencies. The 35 "patients," who were members of the Volunteer Services of each participating hospital, were moulaged with different types of injuries.

The disaster drill also gave officers some practice in using the Incident Command System. Volunteer Chief Bill Brigman (Berwyn Heights Volunteer Fire Department) was Incident Commander; Volunteer Chief Bill Hamilton (14-A Berwyn Heights Volunteer Fire Department), Operations Sector Commander; Paramedic John Harding (Laurel Volunteer Rescue Squad), Transportation Sector Commander; and Chauncey Bowers (EMS Captain, Bureau of Emergency Medical Services), Triage Sector Commander. Assistant Volunteer Chief Eddie Payne (Bladensburg Volunteer Fire Department) was in charge of the Emergency Command Unit and Communications, along with Lt. Linda Jarboe of Fire Communications. George Linnell, Volunteer EMS Liaison Officer at Prince George's Hospital Center, was in charge of logistics and media. Accountability was handled by Volunteer Chief John Sullivan (West Lanham Hills Volunteer Fire Department). Hospital operations were handled by Mark Arsenalt (Prince George's Hospital Center), Nancy Haupt (Doctor's Hospital Center), and Linda Bartko (Laurel Regional Hospital). A total of one ladder truck, 2 squads, 2 fire engines, 8 ambulances, 2 helicopters, and one foam unit responded to the disaster drill scene.

◆ *George Linnell*
*Coordinator, P.G. Disaster Drill*

*U.S. Park Police get ready to Med-Evac a "patient."*



*Triaging "patients" during the disaster drill.*

*Bladensburg Command Center*

# PEMAG Members Named

The Pediatric Emergency Medical Advisory group (PEMAG) was developed to facilitate the identification of needs for pediatric illness emergencies, trauma, and critical care and then recommend statewide enhancement initiatives for the Maryland EMS System. The state PEMAG meets with J. Alex Haller, Jr., MD, the Associate EMS Medical Director of Children's Programs at MIEMSS, and Cynthia Wright-Johnson, MSN, the Administrator for EMSC Programs, to review and develop statewide guidelines and resources and to address issues related to pediatric care for recommendation to the State EMS Medical Directors Committee. PEMAG members welcome your ideas and concerns regarding pediatric emergency care (phone numbers are listed under each member's name).

**Regional Associate Medical Directors for Pediatrics**

***Region I***

**Susan Nuber, MD**
Children's Medical Group,
Cumberland
301-724-7616

***Region II***

**To Be Named**

***Region III***

**Susan Moriarity, MD**
Sinai Hospital, Baltimore
410-578-5324

***Region IV***

**Scott Hamilton, MD**
Peninsula Regional
Medical Center, Salisbury
410-543-7471
and
**William Clendenan, MD**
(alternate)
Peninsula Regional
Medical Center, Salisbury
410-543-7471

***Region V***

**Hammond J. Dugan III, MD**
Prince George's Hospital
Center, Cheverly
301-618-2658/2273
and
**Julia LaJoie, MD**
Holy Cross Hospital
301-905-1225

**Pediatric Trauma Center and Critical Care Resources Representatives**

**Martin Eichelberger, MD**
Director, Emergency
Trauma Services
Children's National
Medical Center, DC
202-884-2154/5188

**Charles Paidas, MD**
Director, Pediatric Trauma
Johns Hopkins Children
Center, Baltimore
410-955-2960

**Dan Ochsenschlager, MD**
Medical Director,
Emergency Medical
Trauma Center
Children's National
Medical Center, DC
202-884-4177/3252

**Ivor Berkowitz, MD**
Asst. Director, PICU
Johns Hopkins Children's
Center, Baltimore
410-955-2393

**Alice Ackerman, MD**
Vice Chair for Clinical
Practice, Pediatric Critical
Care Medicine
University of Maryland
Medical System
410-328-6957

Dr. Moriarity was also selected to serve on the State EMS Medical Directors Committee.

# Md. Ambulance Service Gets National Accreditation

Maryland Ambulance Service, headquartered in Columbia, has recently received a 5-year national accreditation from the Commission on Accreditation of Ambulance Services (CAAS) for its compliance with national standards of excellence.

Maryland Ambulance joins the list of only 40 other ambulance services in the nation to successfully complete the voluntary review process by national experts in EMS. With this achievement, Maryland Ambulance becomes the only ambulance service, public or private, to be accredited in Maryland, Washington, DC, and Northern Virginia.

Maryland Ambulance provides basic and advanced life support medical transportation throughout the Baltimore/Washington region.

CAAS, operated by the American College of Emergency Physicians, is a non-profit organization which was established to encourage and promote quality patient care in America's medical transportation system. "The primary focus of the Commission's standards is high-quality patient care," said Donald Kerns, executive director of CAAS. "This is accomplished by establishing national standards which not only address the delivery of patient care, but also the ambulance service's total operation and its relationship with other agencies, the general public, and the medical community. CAAS' standards often exceed state or local licensing requirements."

Paul Harans, Executive Director of Maryland Ambulance, said accreditation "represents our total commitment to our patients, community, and the medical facilities we serve. Our entire staff strives to maintain the highest standards of patient care and responsiveness, and we view the process of achieving accreditation as part of our ongoing effort toward excellence."

"I think it gives the feeling of prestige and pride to work in an accredited ambulance service," said Christopher Cangemi, NREMT-P, Maryland Ambulance's Special Projects Coordinator.


*Christopher Cangemi, NREMT-P, Special Projects Coordinator, and Jim Courtney, NREMT-P, Assistant Director of Operations, proudly display the CAAS Certificate of Accreditation.*

**Governor Parris N. Glendening**

**Maryland Institute**
**for**
**Emergency Medical Services Systems**

**636 W. Lombard St., Baltimore, MD 21201-1528**

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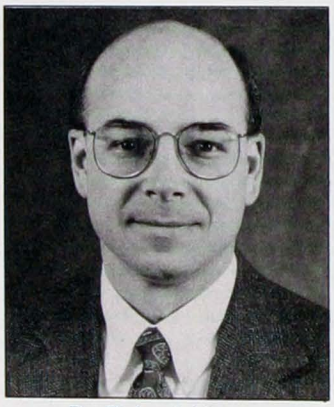
**DATED MATERIAL**

# New State EMS Medical Director Announced



*Dr. Richard Alcorta*

MIEMSS Executive Director Robert R. Bass, MD, after a national search recently announced Richard L. Alcorta, MD, FACEP, as State EMS Medical Director.

Dr. Alcorta's primary responsibilities will be protocol development, medical quality improvement, and base station programs. In addition, he will assist with the medical oversight of EMS system components, such as the training and certification of EMS providers, EMS communications, and public information/education.

Dr. Alcorta is well known to most EMS providers in Maryland. From 1992 to 1994 he was Acting State EMS Director at MIEMSS. Shortly after Dr. Alcorta began in 1992, the Governor's Emergency Medical Services Commission began meeting to review Maryland's EMS system; this led to many significant changes in the organization and administration of MIEMSS and the EMS system. During this time Dr. Alcorta provided a steady leadership and implemented several innovations leading to improved patient care, such as endotracheal intubation for CRTs and the optional procedures allowing EMT-Ps to perform percutaneous needle thoracostomy, transcutaneous external cardiac pacing, intraosseous infusions, nasotracheal intubation, gastric tube placement, and the administration of glucagon and nifedipine.

Before coming to MIEMSS, Dr. Alcorta started his medical career as an EMT-A, worked as a paramedic in urban and rural California settings, and became an emergency medicine physician. He has continued his interest in prehospital care by teaching BLS and ALS providers. In addition, he has been strongly involved in injury prevention and education activities and was a leader in getting the motorcycle helmet law reinstated in Maryland in 1992.

Dr. Alcorta is continuing with "hands-on" patient care by working part-time as an emergency department physician at Suburban Hospital, the areawide trauma center in Bethesda.

◆ *Beverly Sopp*

## Prehospital Case Review

A MIEMSS Prehospital Case Review Program will be held Wednesday, May 31, from 7 to 9 pm, at Washington County Hospital in Hagerstown. Case reviews will focus on patients with adult trauma.

Two hours of B credits for ALS providers and two hours of T credits for BLS providers will be offered for each program.

To register, call the MIEMSS Production Services Office at 410-706-3994.