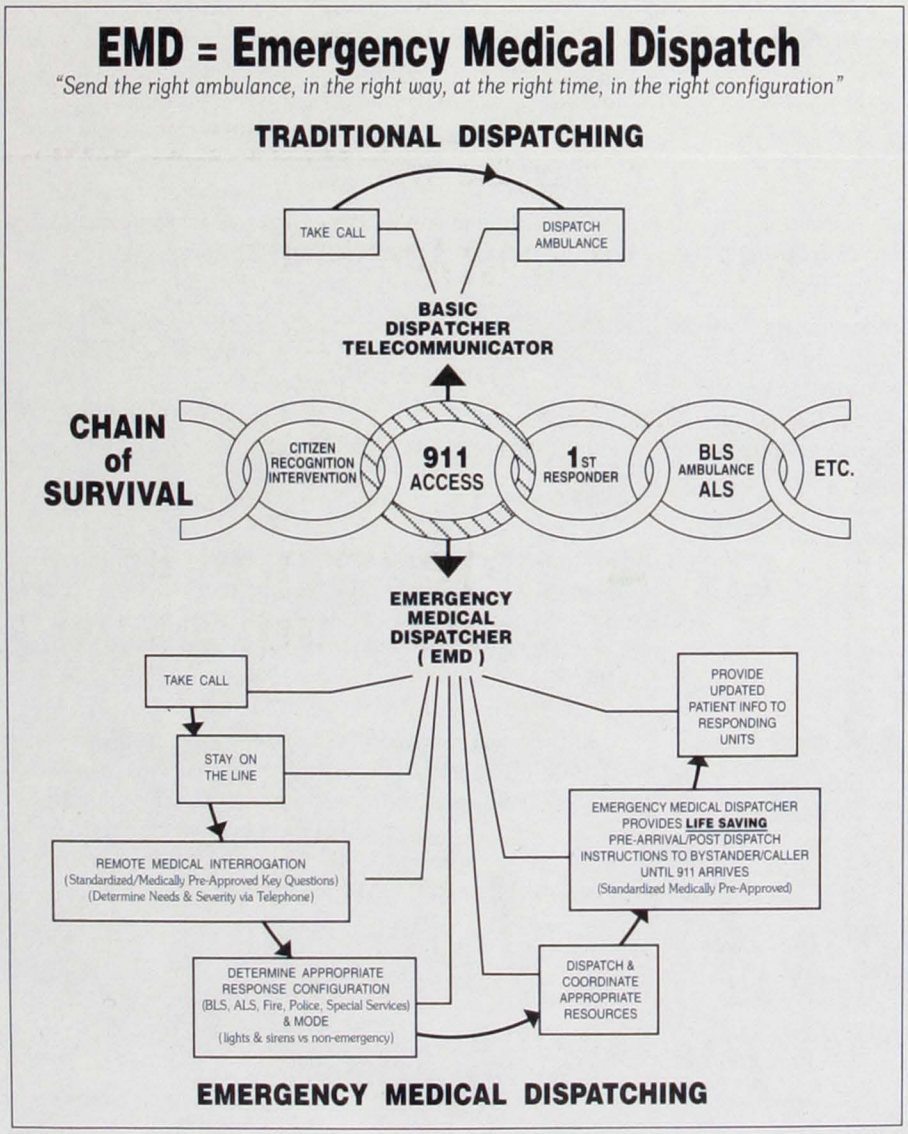
Maryland
EMS News

Vol. 22, No. 4 *For All Emergency Medical Care Providers* March 1996

Update on Emergency Medical Dispatch in MD

Over the past 20 years there have been significant advances in emergency medical services. Emergency medical dispatching has been described by some as the "last frontier" in the EMS continuum of care. The role of the emergency medical dispatcher has expanded in many areas from simply determining the location of an incident and dispatching an ambulance to that of an "EMS professional who plays a key decision-making role on the EMS team."



The term "EMD" is used to describe both an emergency medical dispatch (EMD) program and the medically trained emergency medical dispatchers (EMDs) that these programs utilize. Several local jurisdictions in Maryland already have EMD programs in place in their dispatch centers. A number of others are in the process of evaluating the implementation of an EMD program for their jurisdiction.

A consensus has developed within the EMS community that greater focus on EMD is desirable within our state. As a result of popular media programs depicting idealized EMS scenarios, citizens at large have developed expectations about what their EMS system should be providing them. The idea that pre-arrival instructions will be provided is a prevalent expectation among many citizens that is not a reality in all regions of the country. With the passage of the comprehensive EMS Bill by the Maryland legislature in 1993, and the appointment of the EMS Board, SEMSAC, and the Executive Director of MIEMSS, the environment is now right for the development of statewide standards in this last frontier of EMS, the emergency medical dispatch function.

Consensus recommendations developed by representatives from the state's dispatch centers, the Maryland State Firemen's Association, and the EMS community at a meeting in September 1995 included the following: (1) development of minimum state standards consistent with Department of Transportation (DOT) and the American Society for Testing and Materials (ASTM) standards, (2) a mechanism to recognize all programs that meet minimum standards, (3)

(Continued on page 4)

EMT-Basic Curriculum To Be Implemented

The new US Department of Transportation EMT-Basic (EMT-B) curriculum (125 course hours) will be implemented statewide in Maryland beginning July 1996. Some of the things to remember about the EMT-B program include:

- The emphasis is on assessment, not diagnosis. Students are trained to provide field care based on assessment findings rather than on diagnosis and to treat a condition based on specific signs that they see and symptoms that the patient describes. (For example, an EMT-B will administer oxygen to a patient who has difficulty breathing without determining whether it is caused by myocardial infarction, emphysema, or other diseases.) In classes, lifesaving interaction is stressed more than medical terminology.
- The EMT-B will have basic pharmacological training and will follow medical protocols with "on/off-line" medical direction when administering any medication.

— The EMT-B will be able to assist patients with administering any of the following medications: nitroglycerin, epinephrine auto injector (EpiPen), and unit dose albuterol inhalers. All of these must be previously prescribed for the patient and the patient must have them on hand. If the patient has exceeded his/her dosage, the EMT-B will contact the base station for medical direction to administer additional doses.

— The EMT-B will carry and be able to administer: charcoal with or without sorbitol; Ipecac; and oral glucose. For poisonings, the EMT-B will contact the base station to determine if the patient should receive activated charcoal, Ipecac, or rapid transfer since there are a variety of medications/poisons requiring different interventions.

- The EMT-B will be taught how to use the Automated External Defibrillator (AED).
- The EMT-B will be able to maintain established IV lines containing NO medication.
- The Do Not Resuscitate (DNR) program and the role of the EMT-B will be explained.

According to Richard Alcorta, MD, State Medical Director, "it is important for all EMS providers to understand the new role of the EMT-B, especially its importance during the resuscitation of a patient. It is the continuum of care that will lead to the ultimate survival of the critically ill patient."

The EMT-B curriculum was developed by the National Highway Traffic Safety Administration (NHTSA) as a result of the National EMS Education and Practice Blueprint that was drafted following the NHTSA 1990 consensus workshops on EMS training programs. The Blueprint divides major areas of prehospital instruction and/or performance into "core" elements for which there are progressively increasing knowledge and skill objectives on a continuum of education and practice with each level inclusive of those objectives at the prior level. The core elements are: patient assessment, airway, breathing, circulation, musculoskeletal, children and ob/gyn, behavioral, medical administration, neurological, environmental, EMS Systems, ethical/legal, communications, documentation, safety, and triage and transportation. Currently, the EMT-B program has been implemented by approximately 14 states nationwide, with course hours varying from 120 to 150 hours.

The EMT-B curriculum has been customized for implementation within Maryland by the Basic Life Support Subcommittee of the Education and Training Committee of SEMSAC. The national curriculum is a model, and each state has the option of adding or deleting certain items from the curriculum that it feels necessary. The Basic Life Support Subcommittee refined the curriculum through statewide consensus.

Several pilot EMT-A to EMT-B Bridge courses for EMT-As and EMT-A instructors have been offered in Maryland since September 1995. The curriculum is continuing to be refined through the feedback from participants in and evaluators of these pilot programs. According to Julie Casani, MD, Region III Medical Director and Chairperson of the BLS Subcommittee of SEMSAC, "the comments of the BLS Subcommittee and of the staff members from MFRI, MSFA, MIEMSS, and the training academies who evaluated the pilot courses were extremely helpful. Their suggestions will ensure that Maryland's EMT-B course will meet the needs of future students and that the quality of the training will continue to be of the highest calibre."

You Must Become an EMT-B by Dec. 31, 1999

By January 1, 2000, the EMT-A certification will no longer be recognized in Maryland. The statewide upgrade from EMT-A to EMT-B programs begins in July 1996. The current EMT-A course will no longer be offered as of July 1, 1996. EMT-As with current Maryland certification have until December 31, 1999 to successfully complete the EMT-A to EMT-B Bridge Course. Priority in course enrollment will be given to applicants whose current Maryland EMT-A certification will soon expire. (Beginning July 1, 1996, MFRI will be offering only the 24-hour EMT-A to EMT-B Bridge Course for EMT-As who need to recertify. Any EMT-A recertification programs sponsored by EMS jurisdictions, academies, community colleges, or other training agencies must continue to use the current MIEMSS continuing education approval process.) The plan is to have all EMT-A instructors certified as EMT-B instructors by July 1, 1996. Certifications for both the EMT-B course and the EMT-A to EMT-B Bridge Course are valid for three years. For information about the EMT-B Program, call the MIEMSS Office of Education and Certification (800-762-7157).

Maryland EMT-B Course	***Maryland EMT-A to EMT-B Bridge Course***
• Beginning July 1, 1996, it will replace the EMT-A course.	• Will be offered July 1, 1996 through December 31, 1999
• Provides instruction in essential skills necessary for an individual to provide emergency medical care at a basic life support level.	• Provides continuing education and skills development that will "upgrade" and certify EMT-As as EMT-Bs
• 125 program hours	• 24 program hours
• Prerequisite: current CPR certification (AHA "C" or equivalent)	• Prerequisite: current CPR certification (AHA "C" or equivalent) and Maryland EMT-A certification
• Maryland written exam and patient scenario-based practical exam	• Demonstration of skills proficiency and written pre- and post-evaluations
• Approach to patient care is assessment-based rather than diagnostic-based	• Approach to patient care is assessment-based rather than diagnostic-based
• Course Content – Revised and new materials include: 1. AED 2. Oxygen administration and use of adjuncts 3. Assisted patient medications: EMT-Bs will be able to assist patients in administering their prescribed medications of nitroglycerin, epinephrine auto injector (EpiPen), and unit dose albuterol inhalers. EMT-Bs will carry and be able to administer activated charcoal, Ipecac, and oral glucose. – Maintenance of established IV lines containing NO medications – EMS Do Not Resuscitate (DNR) Protocol – Emphasis on "on/off-line" medical direction – Expanded patient assessment – Body mechanics and lifting techniques – Medical protocols – Emphasis on children, infant, and neonatal resuscitation following the American Heart Association Guidelines – Incorporates enhanced patient-care skills – 10-hour clinical/field internship supervised by a field training coach. Course requires a minimum of 5 patient assessments on actual ambulance runs or in emergency department settings and 5 hours (minimum) EMS orientation.	• Course Content – Revised and new materials include: 1. AED 2. Oxygen administration and use of adjuncts 3. Assisted patient medications: EMT-Bs will be able to assist patients in administering their prescribed medications of nitroglycerin, epinephrine auto injector (EpiPen), and unit dose albuterol inhalers. EMT-Bs will carry and be able to administer activated charcoal, Ipecac, and oral glucose. – Maintenance of established IV lines containing NO medications – EMS Do Not Resuscitate (DNR) Protocol – Emphasis on "on/off-line" medical direction – Expanded patient assessment – Body mechanics and lifting techniques – Medical protocols – Emphasis on children, infant, and neonatal resuscitation following the American Heart Association Guidelines – Reviews enhanced patient-care skills

EMT Courses To Be Offered in July 1996

If you	*Take*
Have never been certified as an EMT-A	EMT-B Course*
Are an EMT-A with current Maryland certification	EMT-A to EMT-B Bridge Course* (must be successfully completed by December 31, 1999) OR EMT-A Recertification Course (If this course is taken, the EMT-A must still complete the EMT-A to EMT-B Bridge Course by December 31, 1999.) NOTE: Beginning July 1, 1996, MFRI will be offering only the 24-hour EMT-A to EMT-B Bridge Course for EMT-As who need to recertify. Any EMT-A recertification programs sponsored by EMS jurisdictions, academies, community colleges, or other training agencies must continue to use the current MIEMSS continuing education approval process.
Are an EMT-A (110 hours) whose Maryland certification has expired (lapsed)	EMT-A to EMT-B Bridge Course*; State EMT-B written and practical exams (Re-entry) NOTE: The period for re-entry is July 1, 1996 - December 31, 1999. The EMT-A to EMT-B Bridge Course must be completed successfully by December 31, 1999. After that time, a former EMT-A with expired Maryland certification will be required to successfully complete the entire EMT-B course.

* Reminder: Current CPR certification (AHA "C" or equivalent) is a prerequisite for this course.

EMD in Maryland

(Continued from page 1)

state certification/recertification of emergency medical dispatchers, and (4) recognition of emergency medical dispatchers as professional components of the EMS system.

In November 1995, the consensus group from the previous month met with emergency operations center (EOC) directors and members of the Central Alarm Advisory Council. A few revisions were made to the EMD consensus document that details the issues involved in, goals of, and process of establishing generic, minimum certification standards for EMD programs in Maryland. It was also agreed that jurisdictions should not be required to implement EMD. However, if EMD was to be used, the programs would have to meet (or to exceed if they so chose) certain minimum standards.

These generic standards would be arrived at by a steering committee appointed by the State EMS Board which would be representative of current proprietary and home-grown EMD programs now operating in Maryland and of jurisdictions that desire an alternative EMD training program. The National Highway Traffic Safety Administration (NHTSA) recently has completed a substantial revision of its EMD National Standard Curriculum. As this article was going to press, the National Standard Curriculum was at the printer. Copies should be available by the time you read this article.

The two major proprietary EMD programs used in Maryland met or exceeded the old National Standard Curriculum. These proprietary programs had input into the new DOT curriculum and it is expected that they will meet or exceed the new National Standard Curriculum.

In November 1995, Robert R. Bass, MD, the Executive Director of MIEMSS, met with the Emergency Number Systems Board, which coordinates the installation and enhancement of jurisdictional 911 systems and allocates funds from the "911 Trust Fund" from other ongoing communications related funds. At that meeting it was resolved that the Emergency Numbers Board would continue its work on the Basic Telecommunicator course which is separate from the EMD training and a prerequisite to it. The Basic Telecommunicator course provides prospective dispatchers with basic communications and dispatch knowledge and skills. Since EMD programs require medical oversight, it was agreed that MIEMSS would take a lead role in the Maryland EMD Program by defining the curriculum and establishing the certification process.

In December 1995, the Maryland Fire and Rescue Training and Education Commission (MFRTEC) was updated on the Maryland EMD Program. MFRTEC develops standards for fire, rescue, and emergency medical education and training. The MFRTEC representatives were supportive of the EMD.

EMD programs offer many benefits to both recipients and providers of EMS service. Pre-arrival instructions can calm family members and bystanders at the scene of an emergency so they can help the victim at the earliest possible time–when the emergency is first determined and the call for help is placed. During response, providers can have the benefit of updated information so they can be better prepared for the situation they are about to encounter. Often the providers will find a more viable patient to work on as a result of the intervention that bystanders

(Continued on page 7)

Emergency Care in an Increasingly Violent Society

Friday, May 31 and Saturday, June 1, 1996

Best Western Maryland Inn
8601 Baltimore Boulevard (Route 1)
College Park, Maryland 20740

Presented by

The Maryland Institute for Emergency Medical Services Systems and the Emergency Education Council of Region V, Inc.

This conference is made possible by a grant from the Board of Visitors of the R Adams Cowley Shock Trauma Center.

This two-day conference will offer both prehospital and hospital emergency medical workers insight into the causes and effects of violence in our society. It also will offer practical tips on self-protection and safe patient care. In addition, the role of emergency care providers in preventing violence will be discussed.

Objectives

The emergency care worker will be able to:

- recognize and defuse potentially violent situations in the emergency care environment
- develop behaviors to minimize personal risk for emergency care workers
- learn conflict resolution techniques
- become familiar with substance abuse as a contributing factor to the escalating violence in society
- learn the ramifications of violence on the families of victims
- recognize and report child abuse
- define the EMS provider's role in violence prevention activities

Accreditation

Prehospital Providers: This program is approved by the Maryland Institute for Emergency Medical Services Systems for continuing education credit. CEUs are listed under each program.
Nurses: This program has been approved for 6 contact hours on Friday, May 31, 1996 and 6 contact hours on Saturday, June 1, 1996 by the Nursing Education Committee at MIEMSS which is accredited as a provider by the American Nurses Credentialing Center on Accreditation.

Registration/Program Costs

Pre-registration is required. Registrations will be accepted until May 24 if space is available. The program cost is $25 per day and includes continental breakfast, lunch, breaks, and program materials. Requests for refunds must be received in writing by May 24, 1996. For information, call 301- 474-1485.

Overnight Accommodations

A block of rooms has been reserved at the Best Western Maryland Inn at $69 per night. Please contact the hotel at 301-474- 2800 by May 6, 1996, to make your reservations. When calling the hotel, tell them you are with Group 900.

Special Needs

Please inform us at least one week in advance of any special accommodations that you require.

Friday, May 31

8:00 - 8:30 am
Registration, Continental Breakfast

8:30 - 9:00 am
Opening Remarks
Robert R. Bass, MD
Executive Director, Maryland Institute for Emergency Medical Services Systems

9:00 am - 10:30 am
Neither Child Nor Adult: The Special Needs and Challenges of the Adolescent in the Emergency Setting
Too often we treat adolescents in the emergency setting who are the victims of violence–either violence directed at them by other adolescents or violence that has been self-inflicted.
Joseph Wright, MD, Maryland's Associate State EMS Medical Director for Pediatrics, will lead a panel discussion on the special challenges of treating these adolescents in the emergency setting.
(1.5 hrs. BLS: M; CRT: A; P: D4, S9)

10:45 - Noon
A. ABC and W
A weapons search during the secondary survey may save a life—yours! This workshop will cover how to conduct a weapons search during a secondary survey and how to recognize some unusual but lethal weapons found in the field.
Capt. Charles W. Brown, NREMT-P
Prince George's County Fire Department
(1.5 hrs. BLS: M; CRT: A; P: D2, S2)

B. Street Drugs
A discussion on how drug usage contributes to the increase of violence in society.
Terry Jodrie, MD
Associate Medical Director, Prince George's County
Emergency Department Physician
Prince George's Hospital Center
(1.5 hrs. BLS: M; CRT: B; P: D4, S7)

C. Domestic Violence
Identification of family violence and intervention in the emergency setting.
Kathy McGarry, RN, CEN, BSN
North Arundel General Hospital
(1.5 hrs. BLS: L; CRT: 2; P: D6, S4)

Noon - 1:00 pm
Luncheon Buffet by the Pool

1:00 - 5:00 pm
D. Emergency Department Safety and Security
An examination of how emergency care workers can recognize potential violence in the emergency care situation, develop strategies to reduce these threats, and protect themselves when there is violence.
Dennis Krebs
Captain, Baltimore County Police Department
Faculty, Department of Defense Counter Narcotics Tactical Operations Medical Support Program
Joshua Vayer
Assistant Professor of Military and Emergency Medicine
Uniformed Services University of the Health Sciences
Director, CONTOMS, Department of Defense
(4 hrs. BLS: L; CRT: 2; P: S2)

1:00 - 4:30 pm
E. Child Abuse
The responsibility of the emergency medical services provider to report child abuse will be discussed, as well as the mechanisms for reporting child abuse and legal ramifications of reporting/failing to report child abuse.
Joy Sakamoto-Wengel, JD
Assistant Attorney General
MIEMSS
(1 hr. BLS: L; CRT: 2; P: D1, S3)

Effects of Violence on Families of Victims
A pediatric psychologist studying the effects of violence on young children of families involved in such incidents will discuss her research.
Debra J. Walther, PhD
Clinical Psychologist
Prince George's Hospital Center
(1.5 hrs. BLS:L; CRT: 2; P: D6, S4)

Violence Prevention Models and a Role for EMS
Representatives of successful mentoring and support programs will discuss what they do and how we can help.
(1 hr. BLS: L; CRT: 2; P: D6, S4)

Saturday, June 1

9:00 am - 4:00 pm
F. Managing Violent Patients in the Hospital Setting
Educators from Springfield Hospital Center will provide practical skills for managing physically violent patients. Casual clothing--slacks or sweats--is recommended. Register early. This program is limited to 20 registrants.
Joanne Coyle, RN, BA
Nursing Instructor
Robert Lippy, LPN
Special Projects Coordinator

9:00 am - Noon
G. Conflict Resolution Techniques for EMS Providers
A member of the Prince George's Conflict Resolution Team will provide valuable pointers on defusing potentially violent situations using proven techniques.
Lt. William Hogewood
Conflict Resolution Team
Prince George's County Police Department
(3 hrs. BLS: L; CRT: 2; P: D6, S4)

Noon
Luncheon Eastern Shore Buffet by the Pool

1:15 - 2:45 pm
H. Defensive Tactics for EMS Providers
How the emergency care worker can reduce the threat of violence in emergency situations or protect himself/herself in the event of violence.
Cpl. Lee Morgan
Prince George's Police Department
(1.5 hrs. BLS: L; CRT: 2; P: D6, S4)

I. Legal Aspects of Patient Restraint
When is the restraint of a violent patient warranted and when is it a violation of the law.
FF/Paramedic Mark Alexander
(1.5 hrs. BLS: L; CRT: 2; P: D1, S3)

J. ABC and W
Repeat of Workshop A.

3:00 - 4:30 pm
K. Defensive Tactics for EMS Providers
Repeat of Workshop H.

L. Legal Aspects of Patient Restraint
Repeat of Workshop I.

M. ABC and W
Repeat of Workshop A.

Registration Form

Name: _____

Address: _____ City: _____ Zip: _____

Daytime Phone: _____ Home Phone: _____

EMS/Hospital Affiliation: _____

Certification Level: (Please Circle All that Apply)

EMT	CRT	EMT-P	1st Responder
LPN	RN	Police Officer	Other: _____

Certification Number: _____

FRIDAY, May 31 PROGRAM

10:45 am - Noon (choose one)

A. ABC and W
B. Street Drugs
C. Domestic Violence

1:00 pm - 5:00 pm OR 1:00 pm -4:30 pm

D. Emergency Department Safety and Security
E. Child Abuse, Effects of Violence on Families of Victims, and Violence Prevention Models

SATURDAY, June 1 PROGRAM

9:00 am - 4:00 pm OR 9:00 am - Noon

F. Managing Violent Patients in the Hospital Setting
G. Conflict Resolution Techniques for EMS Providers

If taking G, choose one from each of the following time periods.

1:15 pm - 2:45 pm (choose one)

H. Defensive Tactics for EMS Providers
I. Legal Aspects of Patient Restraint
J. ABC and W

3:00 pm - 4:30 pm (repeated from above)(choose one)

K. Defensive Tactics for EMS Providers
L. Legal Aspects of Patient Restraint
M. ABC and W

Fees

Friday	$25.00	_____
Saturday	$25.00	_____
Total		_____

Make checks payable to the Emergency Education Council of Region V, Inc.
Mail registration to MIEMSS Region V Office, 5111 Berwyn Rd., College Park, MD 20740.
For information, call: 301-474-1485.

EMS Week: May 19-25

EMS
It's Up To You

EMD in Maryland

(*Continued from page 4*)
provide with the assistance of the emergency medical dispatcher. Providers can also be safer and jurisdictions can reduce their liability by reducing the number of emergency vehicles on the road responding with lights and sirens. Ultimately the patients can get earlier intervention and more appropriate resource allocation for the nature and severity of the medical need. EMD has been shown in many jurisdictions across the nation to save lives.

◆ *George Smith*
Program Development Director, MIEMSS

Governor Parris N. Glendening

Address Correction Requested
MIEMSS, *Maryland EMS News*
636 W. Lombard St., Baltimore, MD 21201-1528

DATED MATERIAL

1st AED Program in Region III

Effective February 1, the Anne Arundel County Fire Department implemented the first jurisdiction-wide automatic external defibrillator (AED) program in the Baltimore metropolitan area. This means that all personnel who respond on emergency apparatus in Anne Arundel County will have been trained to use the AED. The training was accomplished during a six-month period and following an investment of $119,140 in new AEDs.

An AED, which costs about $3,395 and is the state of the art in life-saving technology, automatically analyzes the heart rhythm of an unconscious person and administers an electrical shock to restart the heart of a person in cardiac arrest. Manual defibrillators have been available to provide cardiac monitoring and resuscitation for many years at the county's 13 paramedic units, but can be operated only by paramedics with advanced life support training. AEDs, however, can be operated by county firefighters who are already cross-trained as EMT-As. One AED has already been distributed to every fire station in Anne Arundel County and will be carried by any unit, fire engine, ladder truck, or squad, responding to a medical call.These AEDs are in addition to the defibrillators already on the county's paramedic units.

Communities across the country that have implemented AED programs have experienced as much as a 30% reduction in the mortality rate from cardiac arrests. The Anne Arundel County Fire Department responded to 4,003 cardiac-related incidents in 1994, of which 420 were cardiac arrests. Cardiovascular disease is the leading cause of mortality in Anne Arundel County, accounting for 54% of the deaths. Paul Matera, MD, a fire surgeon for the Anne Arundel County Fire Department and the Vice Chairman of Emergency Services for Providence Hospital in Washington, DC, commented: "The AED program is a key link in the chain of survival for the treatment of out-of-hospital cardiac arrest for the citizens of Anne Arundel County. With the exception of effective early CPR, early defibrillation is the most critical treatment modality leading to increased survival in victims of cardiac arrest."

(L-r) FF. James Womelsdorf, FF. Clyde Keaser, and Lt. Dave Reynolds, from Station 31 of Anne Arundel Co. Fire Dept., respond to an EMS call with an AED.