Maryland
EMS News

Vol. 22, No. 5 *For All Emergency Medical Care Providers* May 1996

New EMT-P Curriculum

The first draft of the new National Standard Curriculum for the EMT-P is finished and ready for peer review. Last year the National Highway Traffic Safety Commission of the U.S. Department of Transportation awarded a contract to the Center for Emergency Medicine of Western Pennsylvania to revise the current standard curriculum.

The curriculum development process uses a small number of group leaders who oversee authors and subject matter experts working on specific areas of the curriculum. Bruce J. Walz, PhD, NREMT-P, associate professor and chairman of the Emergency Health Services Department at the University of Maryland Baltimore County, as one of the group leaders from Maryland, urges the Maryland EMS community to review and comment on the current draft of the new curriculum.

The federal contract specified that all the new curricula (EMT-B, EMT-I, and EMT-P) are to be based on the National EMS Education Blueprint, the Practice Analysis conducted by the National Registry of EMTs, and the recent EMS Futures Meeting. The new paramedic curriculum contains many new sections on the well-being of the paramedic, prevention, therapeutic communications, the challenged patient, and acute interventions in home health care. The proposed EMT-P curriculum also includes 12-lead ECG, rapid sequence induction, and expanded techniques of physical assessment and history taking. A section using case scenarios has been added as a "putting it all together section" to integrate the knowledge, skills, and attitudes taught in the program.

College-level courses in math, English, anatomy, and medical terminology will be a prerequisite for enrollment in EMT-P training. According to the "best guess" estimate of the group leaders, the length of the new curriculum will require 700 hours of didactic and laboratory time. This does not include clinical and field experience, estimated to be approximately 400 hours. Clinical experience will be addressed by another group and it is thought that the clinical experience will be in terms of patient contacts rather than hours.

The federal contract also requires the development of an EMT-I curriculum. The preliminary plan is for the EMT-I to be a generalist, having a broad but limited base of knowledge in all areas of EMS. The EMS Blueprint specifies the skills to be performed by the EMT-I, and these currently include first-line ALS, airway management, chest decompression, and intraosseous infusion. The group leaders are in the process of extracting the EMT-I curriculum from the paramedic one. It is anticipated that the EMT-I will involve approximately 200 hours of didactic and laboratory time, exclusive of clinical experience.

To View the New Curriculum. . .

The current draft of the new paramedic curriculum (version 4.1) is available to the EMS community. The document is rather large so copies cannot be provided free of charge. However, the entire document is available on-line via the Internet. You can view the entire document via this route or download either the entire document or those sections of specific interest. The web site is http.//www.pitt.edu/~paramed. A paper copy can be purchased from the Center for Emergency Medicine of Western Pennsylvania, which was awarded the contract to revise the EMT-P curriculum, by calling 412-578-3187.

Legislative Update

Passed by the Maryland General Assembly, HB 507 will add a representative from the Committee on Pediatric Emergency Medicine of the Maryland Chapter of the American Academy of Pediatrics to the statewide EMS Advisory Council.

In a future newsletter issue, an article will update EMS providers on two proposals that are being worked on and probably will be submitted for the 1997 legislative session. The first proposal would transfer authority and regulate the practice of EMT-Ps and CRTs from the Board of Physician Quality Assurance to the EMS Board; provide clear delineation of the EMS Board's authority to authorize and regulate the practice of EMT-As, EMT-Bs, and First Responders; and establish a recognized program for the training of Emergency Medical Dispatchers in Maryland. The second proposal would add Hepatitis C and certain other diseases to the list of reportable diseases.

Also of interest to EMS providers are the passing of the gun control bill that will limit handgun purchases to one per person per month. The attempt to repeal the motorcyclist helmet law was not successful.

Minor Revisions Made to DNR Form

Since the implementation of the EMS Palliative Care/Do Not Resuscitate (DNR) Program on July 1, 1995, we have been receiving feedback from clinical facilities and other users of the EMS/DNR Program. These comments have prompted a number of revisions to the DNR Order form that will benefit users and have minimal impact on EMS providers. There are four things that EMS providers need to know about the revised EMS/DNR forms:

1. The revised forms (released April 1, 1996) will have eight options instead of seven. The eighth option allows a custodial parent of a minor to sign the EMS/DNR Order. Options 2 and 7 have been modified, as discussed in detail below, but these changes will not impact EMS directly.

2. The look of the revised forms will remain virtually the same. Revised forms will have"Rev. 4/1/96" under the MIEMSS seal in the upper left-hand corner of the form.

3. The original version DNR forms (released 7/1/95) will continue to be valid. Both the original version and the revised version of the EMS/DNR Order form should be honored by EMS providers. Facilities do not need to replace existing, original-version, EMS DNR Orders. They should exhaust their current supply of original forms before ordering revised forms.

4. No change in the protocol is required. Option 3 will continue to be the only Option for which no signature is required in the "Patient or Authorized Decision Maker Statement" section.

Option 2 now covers the patient who is competent, able to communicate by some reliable, proven means (for example, verbally, eye blink, finger tap) but physically unable to sign due to conditions including, but not limited to, blindness, quadriplegia, severe arthritis, amputation, or amyotrophic lateral sclerosis (also known as Lou Gehrig's disease).

Option 7 has been revised to reflect the intent of the Health Care Decision Act that physicians not be required to provide medically ineffective treatment when a patient without decision-making capacity has not left an advance directive and has no agent, guardian, surrogate, or custodial parent.

Finally, the "Patient or Authorized Decision Maker Statement" has been revised to accommodate the changes described above. Cosmetic changes have also been made to improve the readability and clarity of the form. For example, titles have been added for each of the 8 options. Key areas have been bolded or underlined. Clarifying language has been added to the effective date of the form. A reminder has been added that one and only one option must be initialed by the physician.

Samples of the revised DNR Order form and copies of the revised Health Care Decision Act flow chart are available from the MIEMSS Program Development Office.

EMS personnel are reminded that either the form or the bracelet can initiate the Palliative Care/DNR protocol. Both are not required. Nonetheless, some ambulance crews have been insisting on both a form and a bracelet in order to activate the DNR protocol. The only time that crews should be asking for both is when a question is raised as to the validity of the first DNR instrument offered. For example, if there is a question as to the validity of the bracelet, the form can be requested by EMS personnel to quiet any doubts. EMS personnel should be sure to check that all required components of the form or bracelet are completed, including the effective date. The only optional fields are: the social security number field; the authorized decision maker's printed name, when the form is signed by the patient; and the hospice information, when the patient is not in a hospice program. All other fields should be completed in all cases for a DNR Order to be valid.

We have heard much from the users of the DNR program and have been responsive to many of their suggestions. Now we would like to hear from EMS personnel about your experiences with the new EMS Palliative Care/DNR Program and any suggestions you might have for improvements. For example, we are exploring the possibility of adding durable, cosmetic-grade, metal bracelets as an option to the DNR program. If adopted, they would not replace the vinyl bracelets. The vinyl bracelets would continue to serve as a short-term alternative while waiting for a metal bracelet or as the long-term option for those who cannot afford or do not want a metal bracelet. We would like to hear what you see as the pros and cons to this possibility. Remember, this is only under consideration at this time. Metal bracelets have not been adopted as of this writing. If metal bracelets are adopted, you will be notified through your affiliation and a subsequent *Maryland EMS News* update.

Please feel free to contact me at 410-706-4367 to share with me any problems you have experienced or any ideas for improvement, as well as success stories where the program has helped a patient, family, or EMS providers in a substantive way.

◆ *George P. Smith*
Director, Program Development, MIEMSS

Help for Stress

For stress-related issues, contact the MIEMSS Critical Incident Stress Management Team

1-800-648-3001 through SYSCOM

EMS
It's Up To You

FACT SHEET

Emergency Medical Services Week in Maryland
May 19 - 25, 1996

EMS: It's Up To You

This national theme for EMS Week 1996 emphasizes the important role that everyone plays in saving lives. It celebrates the contributions of EMS providers, reaches out to potential recruits, and stresses the importance of strong public support for the EMS system.

EMS Week Goals and Activities

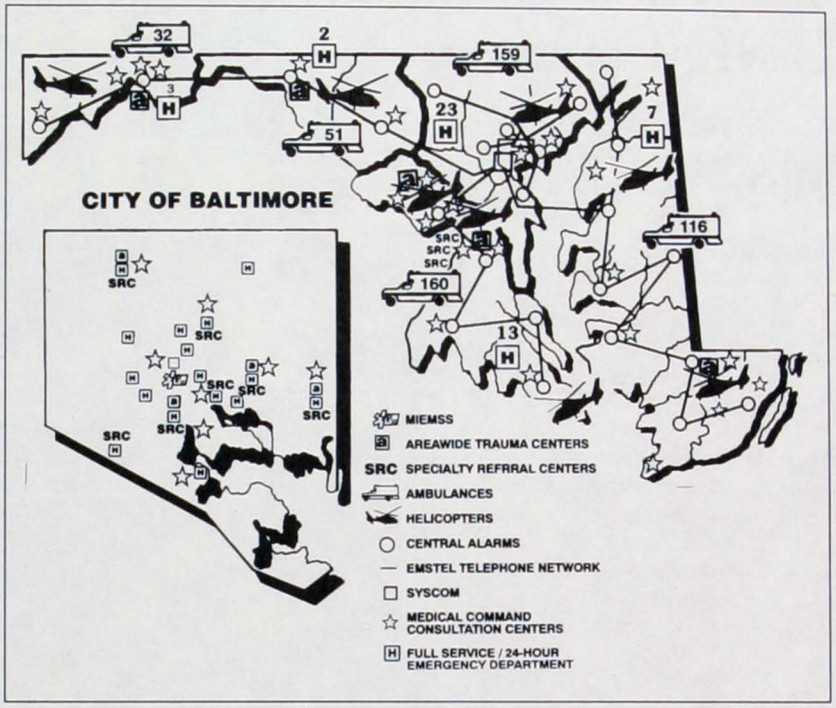
The goals of EMS Week include:

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

During EMS Week, the Maryland Institute for Emergency Medical Services Systems (MIEMSS), the state's coordinating agency for Maryland's EMS System, 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 Provider of the Year; the outstanding EMS program; 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

The Baltimore City Fire Dept. Medical Bureau work on extricating a "patient" during a mock rescue during EMS Week 1995.

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Maryland EMS Statistics

Maryland-Certified Prehospital EMS Providers (FY 1995)

• First Responders	16,850
• EMT-As	16,053
• CRTs	1,137
• EMT-Ps	1,142
TOTAL	35,182

Emergency Care Hospitals (March 1996)

48 Emergency Departments
- 9 Trauma Centers
- 20 Specialty Referral Centers

9-1-1 Centers (FY 1995)

- In Baltimore City and each of Maryland's 23 counties
- More than 600,000 EMS calls in FY 1995

Transports in Maryland*

• Injuries	85,757
• Medical Emergencies	165,238
TOTAL	250,995

Top 10 Injuries in Patients Transported*

• Motor Vehicle Crash	28,135	(32.8%)
• Falls	19,919	(23.2%)
• Beatings	5,575	(6.5%)
• Sports/Rec.	3,748	(4.4%)
• Pedestrian	2,496	(2.9%)
• Industrial	2,205	(2.6%)
• Gunshot Wounds	1,518	(1.8%)
• Stab Wounds	1,166	(1.4%)
• Burn	1,138	(1.3%)
• Bikes	1,063	(1.2%)

Top 12 Medical Emergencies of Patients Transported*

• Myocardial Infarction	18,769	(11.4%)
• Seizure	9,279	(5.6%)
• Diabetes	8,879	(5.4%)
• Asthma	7,413	(4.5%)
• Congestive Heart Failure	6,658	(4.0%)
• Chronic Obstruction Pulmonary Disease	6,299	(3.8%)
• Cerebral Vascular Accident	5,959	(3.6%)
• Overdose	4,722	(2.9%)
• GI	4,489	(2.7%)
• OB/GYN	4,262	(2.6%)
• Behavioral	3,075	(1.9%)
• Cardiopulmonary Arrest	3,011	(1.8%)

Neonatal Transports (FY 1995)

• Neonatal ambulance	340
• Helicopter	149
• Helicopter/ambulance	7
TOTAL	496

Med-Evac Helicopter Program (FY 1995)

- 11 helicopters
- 8 bases
- 44 flight paramedics
- 56 pilots
- 3,531 transports (85%) from scene of injury
- 612 interhospital transports (15%)

Commercial Ambulances (March 1996)

- 44 Licensed Services
- 102 Licensed ALS Ambulances
- 238 Licensed BLS Ambulances

Maryland Poison Center Calls (Calendar Year 1994)

- 57,359 total calls
- 19,609 requests for information
- 37,750 calls regarding human exposure to poison

Sources of Human Exposure Calls

- From general public	81.0%
- From physicians	14.9%
- From prehospital providers, pharmacists	4.1%

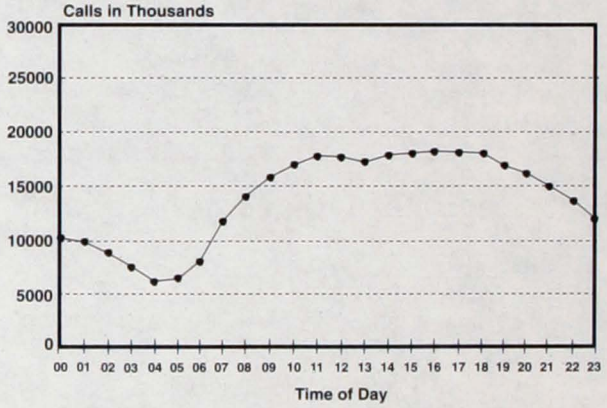
Age of Patients Exposed to Poison

- Younger than 6 yrs.	53.3%
- 6-12 yrs.	5.6%
- 13-19 yrs.	7.8%
- 20-69 yrs.	28.3%
- 70 yrs. and older	1.7%

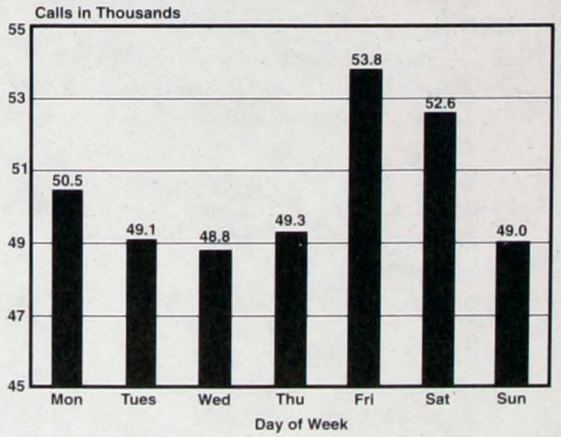
Transports in Maryland by Age and Type of Emergency*

Age	Injury	Medical
1-30 days	104 (0.1%)	485 (0.3%)
30d-5 yrs.	3,151 (3.7%)	4,485 (2.7%)
6-15 yrs.	8,062 (9.4%)	5,346 (3.2%)
16-60 yrs.	52,125 (60.8%)	74,594 (45.1%)
60+ yrs.	16,899 (19.7%)	65,380 (39.6%)

EMS Demand in Maryland by Time of Day*



EMS Demand in Maryland by Day of Week*



* Based on MAIS FY 1995 (July 1, 1994 to June 30, 1995) data that do not include Montgomery and Prince George's counties.

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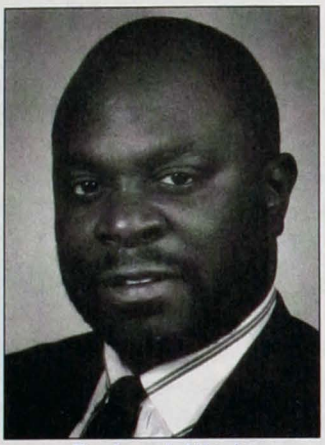
Taking a New Approach to Pediatric Emergencies



Dr. Joseph Wright

Joseph Wright, MD, MPH, recently appointed Associate State EMS Medical Director for Pediatrics, sees an evolution occurring across the country in the way that pediatric emergency care is taught. "We are going from teaching EMS providers how to deal with children in life-threatening situations to using a more detailed and comprehensive approach encompassing child development and seeing the child in the context of the family and community. . . . Prehospital training in resuscitation and emergency treatment is essential. But if we want to prevent morbidity, we need to start identifying risks that children face every day."

To do this, Dr. Wright says we need a public health approach, such as that used to mitigate such problems as smoking and seatbelt use. "The first step in the public health approach, which is a time-tested, well-defined approach to problem-solving, is problem definition. EMS has a tremendous advantage in this area because we have access to patients and therefore data and information that can be used to define problems. After a problem is defined, causes and risk factors can be identified and solutions and interventions developed. The last step is the implementation of those interventions. EMS and emergency medicine have a role in each of those steps, although long-term solutions must come from the community and institutions."

A public health approach requires a new mind-set for EMS providers who traditionally have been trained to be problem oriented and to focus only on the patient. According to Dr. Wright, "although this must certainly remain a priority, we cannot shut our eyes to the larger problems that are bringing patients to our front doors."

In taking a public health approach, prehospital providers should take advantage of their skills of observation and vigilance. "At the scene, prehospital personnel take in valuable information about circumstances, setting, and the home environment. My hope is that we can develop an ED-based repository for the downloading of this information such that risk assessment and appropriate referrals can take place. I do not see the emergency setting as a venue for comprehensive social work and broad intervention, but we can certainly identify risks and targeted interventions to address the risks. As an emergency physician, I can say that prehospital providers are my eyes in the street. For example, every year when the weather turns warm, we have children falling from windows. Providers at a scene can tell me they've just come from a tenth-floor apartment that had no bars on the windows and there are young children there. We could then prevent some of those falls if we took the

(Continued on page 6)

About Dr. Wright. . .

Joseph L. Wright, MD, MPH, recently was appointed Associate State EMS Medical Director for Pediatrics by MIEMSS Executive Director Robert R. Bass, MD. Dr. Wright replaces J. Alex Haller, MD, who is retiring.

Dr. Wright will be working part-time at MIEMSS and continuing as the Assistant Director of the Emergency Services Department at Children's National Medical Center (CNMC) in the District of Columbia. (CNMC and the Johns Hopkins Children Center are the pediatric specialty referral centers in Maryland's EMS system.) In addition, Dr. Wright is an Assistant Professor in both the Pediatrics and Emergency Medicine departments at the George Washington University School of Medicine and Health Sciences. Dr. Wright has been a resident of Upper Marlboro in Prince George's County for six years.

Before working in the Maryland-DC area, Dr. Wright was an emergency pediatrician in Brooklyn, New York and Newark, New Jersey. In the U.S. Public Health Service, he served as Director of Adolescent Medicine at the Lyndon Baines Johnson Health Complex in Brooklyn, New York.

Dr. Wright received his Doctor of Medicine degree from the New Jersey Medical School of the University of Medicine and Dentistry of New Jersey. He was both a pediatric resident and emergency medicine fellow at the Children's National Medical Center. In 1994 he completed his Master of Public Health degree in Administrative Medicine and Management at the George Washington University School of Medicine and Health Sciences.

Dr. Wright has served on numerous national and regional committees for such organizations as the American Academy of Pediatrics, the National Center for Injury Control and Prevention of the Centers for Disease Control (CDC), the Emergency Medical Services for Children program, and the National Safe Kids Coalition.

In May, he will speak at the Violence Conference presented by MIEMSS and the Emergency Education Council of Region V, Inc.; his topic will be the special needs and challenges of the adolescent in the emergency setting.

EMS Plan Survey Analysis

In August 1995, the EMS Board approved the new EMS plan for the State of Maryland, which contains 99 objectives providing the framework for bringing Maryland's EMS system into the next century. In October 1995, MIEMSS distributed a statewide survey to system providers to determine which 10 objectives they felt were top priorities for implemer tation. See page 7 for listing.

Trends Indicated

• Priority objectives that were common to both the volunteer and career providers addressed: adoption of a national blueprint and funds for education, equipment, and technology; funds for EMS operations, research, and training; legislation to protect against abandonment liability in threatening scene situations; and a statewide EMD program.

• Objective 600 is overwhelmingly the most popular objective. Nearly one-half of the providers who responded believed that this particular objective should be one of Maryland's priorities. Among all relevant groups included in the survey, only first responders, hospital administrators, and statewide representatives did not place Objective 600 in their top three choices.

• One-third of all providers who responded believed that Objective 690 should be an important consideration.

• Six of the ten most significant objectives according to the overall response population are from the Human Resources section of the Plan's objectives.

• Prehospital ALS providers are interested in the Human Resources objectives that focused on certification issues and scope of practice.

• All five regions ranked Objective 600 as one of their top three priority objectives.

◆ *Ronald M. Kropp*

Thank You!

On behalf of the Ocean City Emergency Medical Services, we would like to sincerely thank all those who sponsored or participated in "EMS Seminar '96." Without your help, the conference would not have been a success.

---Debbie Patterson,
EMS Seminar Coordinator

Pediatric Emergencies

(Continued from page 5)

responsibility of reporting our observations about the environmental risks so an appropriate referral can be made."

A major problem in many emergency departments is injury recidivism. Dr. Wright recalls that when he went into emergency medicine he never thought he would grow familiar with the faces of patients, particularly adolescent patients. "It's disturbing to see the same patients coming in repeatedly, many with penetrating injuries. After treatment, these patients return to the same high-risk environments and behavior that initially brought them to the emergency department."

He admits that the process of changing human behavior is slow. It is sobering to realize that there is no "quick fix" for the problem of violence.

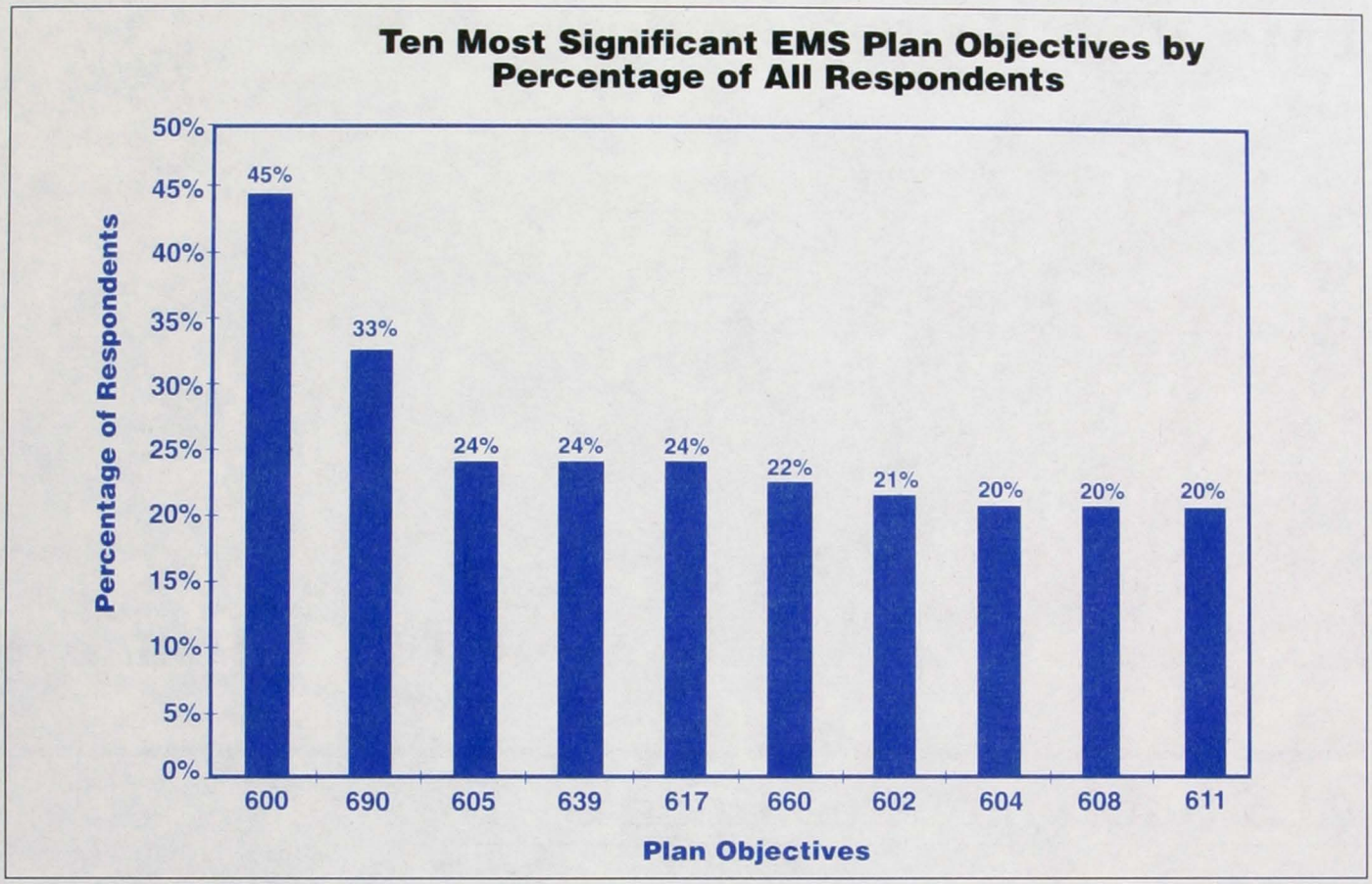
Dr. Wright is currently involved in a training initiative for prehospital providers focused on adolescents and young adults. Through workshops, EMS providers learn to recognize cultural differences that come out in a variety of behaviors. "I'm not trying to make EMS providers social workers or psychologists on the street. But we should be aware that our own behaviors need to show tolerance and respect for differences." Patients often have values, beliefs, and perceptions that are very different from those of the EMS providers and that influence how patients behave and impact on providers' behavior. Recognizing and understanding this will increase the ability of EMS providers to communicate effectively and offer better care to their patients.

Dr. Wright believes that "EMS providers need to be able to take advantage of what I call the 'teachable moment,' that period of time when the patient is in a vulnerable, receptive position and the provider has a chance to talk to him after the ABCs are done and medical stability has occurred. Usually there is an opportunity in emergency situations to employ some teaching or 'reality orientation.'" For example, adolescents do not always know what has happened to them and the future consequences of that action. They may need to be told that their present scenario is unlike what they see on TV— for example, bullets do hurt, they will not be getting off the stretcher and going home immediately, and their future life may be very different from their present one as a result of their injuries. EMS providers should not assume that cognitive and emotional maturity is equal to physical maturity or age, and should talk to teenagers very concretely and in tangible and basic terms. "And one thing we can't be is judgmental; that is easily sensed by teenagers and no one responds to it. To engage a teenager in conversation, we need to ask open-ended questions, not leading or incriminating ones."

Adolescents and young adults represent only one segment of patients who have contact with EMS providers. But they represent one of the most dynamic in terms of variety of behavior and different levels of physical, cognitive, and emotional development.

The future direction of EMS, Dr. Wright feels, will focus on tackling problems from the public health perspective. This means that EMS providers will be broadening their scope, looking at patients not as medical problems but as individuals with medical problems and at the risk factors that may have contributed to the medical problems. The EMS providers will have a vital role not only in treatment but in prevention.

◆ *Beverly Sopp*



Note: *In order to avoid exceeding 10 objectives, Objective 629 was not included in the Top Ten list, but is recognized to be equally significant to 604, 608, and 611.*

600 Adopt national "blueprint" for all levels of prehospital certification, including intermediate, within an acceptable timeframe and ensure appropriate funding for the training and education of EMS providers of the state, to include equipment and technology necessary to ensure proper applications of state-of-the-art techniques and exploration of new teaching modalities.

690 Pursue funding to support EMS operations, research, and training.

605 Ensure that workers' compensation coverage is provided to all EMS providers.

639 Suggest legislation to protect EMS providers from abandonment liability in threatening scene situations.

617 Design and implement a statewide protocol and training program for pre-arrival instructions given by call takers and dispatch personnel.

660 Establish and clarify the lines of authority, responsibility and accountability, and qualifications, including job descriptions and, as appropriate, contracts and reimbursement arrangements, for medical directors and others involved in medical control.

602 Provide a mechanism to allow current CRTs to voluntarily obtain national level intermediate or paramedic certification while allowing those desiring to maintain current CRT certification or equivalent to do so until voluntarily surrendered.

604 Assure jurisdictional medical director's authority to include BLS, for the purpose of protocols, scope of practice, and Continuous Quality Management (CQM).

608 Encourage volunteerism by use of public service announcements, volunteer recognition programs, and other means.

611 Encourage the training of hospital personnel in EMS practices and equipment enhancements.

629 Facilitate collaboration and encourage cooperation among hospital emergency departments and providers.

MIEMSS "Adopts" Family

MIEMSS employees "adopted" a family of nine, including seven children ranging from 5 to 10 years of age. The youngest has cancer. At Christmas and Easter, MIEMSS employees donated food and money; several gifts for each family member also were given at Christmas. Jim Brown seemed to reflect the feelings of many MIEMSS staff when he said that he felt good about the way the "agency really pulled together to make a difference in the way that our adopted family was able to celebrate Christmas and Easter."

Governor Parris N. Glendening

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DATED MATERIAL

ALS Subcommittee Update

The Advanced Life Support (ALS) Subcommittee of the Statewide EMS Advisory Council (SEMSAC), chaired by Andrew Sumner, MD, is working on an ALS program accreditation process. The Board of Physician Quality Assurance currently certifies ALS instructors to teach. The process proposed by the ALS Subcommittee would accreditate ALS educational programs rather than certify individual instructors. ALS instructor programs would be able to select those they feel qualified to teach ALS programs and to choose the clinical sites.

ALS program accreditation will foster and support local and institutional ALS education in Maryland. Ensuring quality, standardization, and cost-effective ALS instruction, it will allow for local program control with quality management oversight at the state level.

The ALS Subcommittee also has surveyed EMS and commercial jurisdictions to determine which ALS programs have preceptorships/ internships. The survey results are currently being summarized.

In Fiscal Year 1996 MIEMSS increased ALS funding support to meet the additional requests for new programs. MIEMSS will no longer provide ALS textbooks, but will place the money spent on textbooks in the past into one ALS funding source that includes course support money. Currently, funding for Fiscal Year 1997 is being addressed by the Regional Affairs Committee of SEMSAC. They are looking at the process and formula for distributing funds regionally, similar to the funding process for defibrillators and AED equipment.

Emergency Care in an Increasingly Violent Society

Friday, May 31 and Saturday, June 1, 1996
Best Western Maryland Inn (College Park)

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

For registration and information, call 310-474-1485.